LIBRARY

BOSTON
UNIVERSITY

COLLEGE
OF
BUSINESS
ADMINISTRATION

Class No. *368.42
Book No. So4m c.1
Acc. No. 34819
Date 3-14-46

BOSTON UNIVERSITY

College of Business Administration

THESIS

Medical Insurance in Industry

by

Joseph H. Solomon

(A. B. College of William and Mary 1943)

submitted in partial fulfillment of
the requirements for the degree of

Master of Business Administration
1946

Digitized by the Internet Archive
in 2017 with funding from
Boston Library Consortium Member Libraries

https://archive.org/details/medicalinsurance00solo

3-14-46
34819
f368.42
S04m
c.1

MEDICAL INSURANCE IN INDUSTRY

Table of Contents

Page Number

List of Tables XIV

List of Sample Forms XVIII

Chapter I

Medical Insurance--Introduction

A. Purpose of Thesis

1. Analysis, Evaluation, Investigation, and Comparison of Medical Insurance Plans ... 1
2. Recommendations 1

B. Need for Medical Insurance

1. Extent and Cost of Invalidity 1
2. Existing Provisions for Medical Care 6

C. Present Status of Medical Insurance

1. Public Attitude and Investigations 8
2. Present Day Plans and Policies 9

D. Development of Prepayment Plans

1. Origin and Growth of Different Types of Plans to 1920 14
2. Development since 1920 13

E. Features of Medical Insurance Plans

1. Important Questions 14
2. Main Characteristics 15
   a. Origin and Development 15
   b. Eligibility and Coverage 15
   c. Administration 15
   d. Financial Arrangements 15
   e. Scope of Service 18
   f. Quality of Service 20

F. General Medical Opinions

1. Committee on the Costs of Medical Care .. 21
2. Individual Opinions 24

Table of Contents (Continued)

Page

a. Senator Leverett Saltonstall 24
b. Dr. Roger Lee 24
c. Dr. Charles Willinsky 26
d. Dr. Elmer Bagnell 26
e. Dr. Alan Butler 27
f. Dr. Nathanial Faxon 29

G. Plans to be Discussed and Bases of Comparison

1. Plans Not Sponsored by Industries 32
2. Plans Sponsored by Industries 33
3. System of Weighting 34
4. Desirable and Undesirable Features 35
  a. Desirable features 35
  b. Undesirable features 37

Chapter II

Local, State, Federal, and Foreign Government Insurance Plans

A. Arguments for and against Government Insurance

1. Arguments for Government Insurance 41
2. Arguments for Voluntary Insurance 43

B. Local Plan--New York City (Proposed)

1. Origin and Development 45
2. Eligibility and Coverage 46
3. Administration 46
4. Financial Arrangements 47
5. Scope of Service 48
6. Conclusions 49

C. State Plan--Rhode Island

1. Origin and Development 49
2. Eligibility and Coverage 49
3. Administration 50
4. Financial Arrangements 50
5. Cash Benefits 51
6. Conclusion 51

D. State Medical Insurance Proposals and Investigations

1. New Hampshire 54
2. Massachusetts 55

Table of Contents (Continued)

E. State Plan--Proposed Model Bill Page

1. Eligibility and Coverage 57
2. Administration 57
3. Financial Arrangements 57
4. Scope of Service 58
5. Conclusion 59

F. Federal Plan--The Standard Bill

1. Origin and Development 59
2. Eligibility and Coverage 60
3. Financial Arrangements and Cash Benefits. 60
4. Conclusions 60

G. Federal Plan--The Wagner-Murray-Dingell Bill (Proposed)

1. Origin and Development 61
2. Eligibility and Coverage 62
3. Administration 62
4. Financial Arrangements 65
5. Scope of Service 66
6. Quality of Care 66
7. Conclusion 66

H. Health Insurance Plans of Foreign Governments

1. General Description 71
2. Denmark 72
   a. Origin and Development 72
   b. Eligibility and Coverage 72
   c. Administration 74
   d. Financial Arrangements 74
   e. Scope of Service 75
   f. Conclusions 75
3. Germany 75
   a. Origin and Development 75
   b. Eligibility and Coverage 76
   c. Administration 76
   d. Financial Arrangements 77
   e. Scope of Service 77
   f. Conclusions 77
4. Great Britain 81
   a. Origin, Development, Eligibility and Coverage 81
   b. Administration 82
   c. Financial Arrangements 82
   d. Scope of Service 83
   e. Quality of Care 83
   f. Conclusions 84

Table of Contents (Continued)

Page

5. France 89
  a. Origin and Development 89
  b. Eligibility and Coverage 90
  c. Administration 90
  d. Financial Arrangements 90
  e. Scope of Service 91
  f. Quality of Care 91
  g. Conclusions 92
6. Russia 92
7. New Zealand 93
  a. Eligibility, Coverage, and Administration................................. 93
  b. Financial Arrangements, Scope of Service, and Quality of Care 93
  c. Conclusions 93

I. Conclusions 94

Chapter III

Voluntary, Private Association, Medical Society, Group Clinic, and Cooperative Plans

A. Voluntary Non-Profit Private Association Plans

1. Opposition to Compulsory Plans 97
2. Accomplishments 98
3. Voluntary Plans in Massachusetts 100
4. The Massachusetts Blue Cross Plan 102
  a. Origin and Development 102
  b. Eligibility and Coverage 105
  c. Administration 105
  d. Financial Arrangements 106
  e. Scope of Service 107
  f. Conclusion 108

B. Medical Society Plans

1. Origin and Development of Medical Society Plans 109
2. Michigan 110
  a. Origin and Development, Eligibility and Coverage, and Administration of the Medical and Surgical Plans 110
  b. Financial Arrangements of the Surgical Plan 111
  c. Scope of Service of the Surgical Plan 112
  d. Conclusions 112
3. California 113
  a. Origin and Development 113
  b. Eligibility and Coverage 113

Table of Contents (Continued)

Page

c. Administration 114
d. Financial Arrangements 114
e. Scope of Service 114
f. Problems and Conclusions 115
4. Massachusetts 116
a. Origin and Development 116
b. Eligibility and Coverage 117
c. Administration 117
d. Financial Arrangements 118
e. Scope of Service 118
f. Conclusions 119
5. New Jersey 120
a. Origin and Development 120
b. Eligibility and Coverage 121
c. Administration 121
d. Financial Arrangements 121
e. Scope of Service 122
f. Conclusions 122
6. General Appraisal 122
7. Attitude of the American Medical Association 123
8. Conclusions 126

C. Private Group Clinic Plan--The Ross-Loos Medical Group

1. Eligibility and Coverage 127
2. Administration 127
3. Financial Arrangements 127
4. Scope of Service 128
5. Quality of Care 128
6. Conclusion 128

D. Cooperative Plans of Tampa, Florida

1. General Nature--Eligibility, Administration, Finances, and Services 128
2. Conclusions 130

Chapter IV

Labor Organization and Commercial Insurance Company Plans

A. Labor Organization Plans

1. General Development 132
2. Union Plan--International Ladies' Garment Workers' Union 135
a. Origin and Development, Eligibility and Coverage 135
b. Administration 137

Table of Contents (Continued)

Page
c. Financial Arrangements 137
d. Scope of Service 137
e. Conclusions 139
3. Union Plan--Cafeteria Employees' Union, Local 302, New York 142
a. Eligibility and Coverage 142
b. Administration and Financial Arrangements 142
c. Scope of Service 142
d. Quality of Care 142
e. Conclusions 143
4. Union Plan--International Workers Order ... 143
a. Eligibility and Coverage 143
b. Administration 143
c. Financial Arrangements 143
d. Scope of Service 144
e. Quality of Care 144
f. Conclusions 144
5. Other Union Plans 144
a. Chicago Packing House Workers' Union 145
b. Chicago Post Office Clerks Union 145
c. Chicago Teachers' Union 145
d. Ford Automobile Workers' Union 146
e. United Automobile Workers' Union--Detroit 147
f. Other Unions 147

B. Commercial Insurance Company Plans

1. Prevailing Conditions 148
a. Opposition to Wagner Bill 148
b. Financial Arrangements 150
c. Cash Benefits 151
d. Conclusions 151
2. The Prudential Insurance Company of America 154
a. Origin and Development 154
b. Eligibility and Coverage 155
c. Administration and Financial Arrangements 155
d. Cash Benefits 157
e. Conclusions 158

Chapter V

Plans Sponsored by Industries, Their Employees, or Both--Introduction

A. Need 160

B. Opinions 163

1. Favorable Industrial Opinions 163
2. Unfavorable Industrial Opinions 167

Table of Contents (Continued)

Page

3. Opinions of the Surgeon General of the United States Public Health Service and the National Physicians Committee for the Extension of Medical Service 168
  a. National Health Program of the National Physicians Committee for the Extension of Medical Service 169
  b. National Health Program of Dr. Thomas Parran, Surgeon General of the U. S. Public Health Service 169
4. Opinions of Physicians and Medical Administrators 170
  a. Dr. I. S. Falk 170
  b. Dr. Nathan Sinai 170
  c. Dr. J. Roy Hege 170
  d. Graham Davis 170
  e. George St. J. Perrot 170
5. Political Opinions 171

C. Goals and Achievements 173

D. Classification of Plans 176

1. Cash Benefit Plans 177
  a. Non-Contributory Plans Financed by the Company 178
  b. Joint Employer-Employee Plans 179
  c. Employee Plans 179
  d. General Problems of Cash Benefit Plans . 179
2. Medical Service Plans ....
  a. General Problems of Medical Service Plans 181
  b. Administration 181
  c. Financial Arrangements and Eligibility . 182
  d. Scope of Service 182
  e. Quality of Service 182

Chapter VI

Non-Contributory Plans

A. Non-Contributory Cash Benefit Plan--The New England Telephone and Telegraph Company

1. Eligibility, Administration, and Financial Arrangements 185
2. Cash Benefits 185
3. Limited Medical Program 187

Table of Contents (Continued)

Page

4. Miscellaneous Features 188
5. Conclusions 189

B. Non-Contributory Cash Benefit and Hospitalization and Surgical Benefit Plan--Boston Edison Company

1. Origin and Development--1940 Study ... 189
2. New Cash Benefit Plan 190
3. Hospital and Surgical Benefit Plan ... 191
4. Dependents' Plan 192
5. Company Medical Department 193
6. Conclusion 193

C. Non-Contributory Medical Service Plan--Endicott Johnson Company

1. Origin and Development 194
2. Eligibility and Coverage 195
3. Financial Arrangements 196
4. Scope of Service 196
5. Conclusion 198

D. Non-Contributory Medical Service Plan--American Tobacco Company and American Supplies Inc.

1. Location 199
2. Eligibility and Coverage 199
3. Administration and Financial Arrangements 199
4. Scope of Service 200
5. Quality of Service 200
6. Conclusions 200

E. Non-Contributory Medical Service Plan--The American Cast Iron Pipe Company

1. Origin and Development 201
2. Eligibility, Coverage, Administration, and Financial Arrangements 201
3. Scope of Service 202
4. Conclusion 202

F. Non-Contributory Medical Service Plan--The Paraffine Company Inc.

1. Eligibility and Coverage 204
2. Administration and Financial Arrangements 204
3. Scope of Service 204

Table of Contents (Continued)

Page

4. Quality of Service 205
5. Conclusion 205

Chapter VII

Joint Employer-Employee Plans

A. Joint Employer-Employee Cash Benefit Plan--Batchelder and Snyder Company Inc. 206

1. Eligibility and Administration 206
2. Financial Arrangements and Cash Benefits 207
3. Conclusions 208

B. Joint Employer-Employee Cash Benefit Plan--General Electric Company 209

1. Boston Office Plan 209
2. Company Group Sickness, Accident, and Hospital Expense Benefit Plan 209
3. Dependents' Hospital Expense Benefit Plan 211

C. Joint Employer-Employee Medical Service Plans--Binghampton, New York 211

1. Dunn and McCarthy Shoe Factory 211
2. Spaulding Bakeries 213
3. Ansco Corporation 213
4. The Binghampton Die and Machine Company 213
5. Conclusions 213

D. Joint Employer-Employee Medical Service Plan--Consolidated Edison of New York .. 214

E. Joint Employer-Employee Medical Service Plan--Tennessee Coal, Iron, and Railroad Company 215

1. Origin, Development, and Administration 215
2. Eligibility and Coverage, and Financial Arrangements 216
3. Scope of Service 216

Table of Contents (Continued)

Page

4. Quality of Care 218
5. Conclusions 218

F. Joint Employer-Employee Medical Service Plan--Tennessee Valley Authority 218

1. Origin and Development 218
2. Eligibility and Coverage 219
3. Administration 219
4. Financial Arrangements 220
5. Scope of Service 220
6. Conclusions 221

G. Joint Employer-Employee Medical Service Plan--Henry J. Kaiser Shipyards 221

1. Origin and Development 221
2. Richmond California Shipyards 223
   a. Eligibility, Coverage, and Financial Arrangements 223
   b. Scope of Service 224
3. Northern Permanente Foundation, Vancouver, Washington 225
4. Southern Permanente Foundation, Fontana, California 226
   a. Eligibility and Coverage 226
   b. Financial Arrangements 226
   c. Scope of Service 226
   d. Quality of Care 227
5. Family Plan 227
6. Conclusions 227

H. The Trend 229

I. Conclusions 230

Chapter VIII

Employee Plans

A. Employee Cash Benefit Plan--William Filene's Son's Company

1. Old Plan 232
   a. Origin and Development 232
   b. Eligibility and Coverage and Administration 233
   c. Financial Arrangements 234

Table of Contents (Continued)

Page

d. Cash Benefits 234
e. Conclusions 235
2. New Plan 235
3. Other Medical Services 236

B. Employee Cash Benefit Plan--Lynn Riverworks of General Electric Company

1. Eligibility and Administration 237
2. Financial Arrangements 238
3. Cash Benefits 239
4. Special Provisions 239
5. Conclusions 240

C. Employee Cash Benefit Plan--American Bosch Mutual Benefit Association

1. Origin and Development 240
2. Eligibility and Coverage 240
3. Administration 241
4. Financial Arrangements 241
5. Cash Benefits 242
6. Conclusion 243

D. Employee Medical Service Plan--Colonial Beacon Oil Company

1. Eligibility and Coverage 244
2. Financial Arrangements 244
3. Scope of Service 245
4. Conclusions 245

E. Employee Medical Service Plan--Standard Oil Company of Louisiana (Stanocola)

1. Origin and Development 246
2. Eligibility and Coverage and Administration 248
3. Financial Arrangements 249
4. Personnel and Facilities 249
5. Scope of Service 251
6. Volume of Service 252
7. Quality of Care 252
8. Conclusion and Advantages 255

Table of Contents (Continued)

Page

Chapter IX

Conclusions

A. The Present Situation

1. Eligibility and Coverage 257
2. Administration 259
3. Financial Arrangements 262
4. Scope of Service 262

B. A Comparison of Plans and Weights

1. Basis of Comparison 264
2. Comparison of Plans 267
   a. Eligibility and Coverage 271
   b. Administration 272
   c. Financial Arrangements 272
   d. Scope of Service 273
   e. Quality of Care 274
   f. Conclusion 275
3. Health Program Conference 277
   a. Proposals 277
   b. Evaluation 278
4. Recommendations 280
   a. Objectives and Need 280
   b. Eligibility and Coverage 280
   c. Administration 280
   d. Financial Arrangements 282
   e. Scope of Service 283
   f. Quality of Care 284
   g. Conclusions 285

Appendix I Original Tables (See List of Tables on Page XIV)............................ 287

Appendix II Sample Forms of the New England Telephone and Telegraph Company (See List of Sample Forms on Page XVIII)...................... 295

Bibliography 310

List of Tables

Table Number	Title	Page Number
1.	Expenditures for Medical Care and Volume of Service Received According to Economic Status (Eighty-six Hundred Families 1928-1931)...........	3
2.	Total Expenditures for Medical Care in the United States in 1929 in Thousands of Dollars	5
3.	Incomes of Various Professional Groups, 1929	7
4.	Bed Capacity According to Control and Type of Service, 1936	7
5.	Fortune's Poll on Public Attitude	8
6.	Form Used for Analysis of Costs--Sample Operating Statement	16
7.	Division of Income, 1932	23
8.	Compulsory Health Insurance Plans	73
9.	Major Developments of Sickness Insurance in Germany	78
10.	Major Developments of National Health Insurance in Great Britain	86
11.	Financial Features of British Health Insurance	87
12.	Group Insurance in Massachusetts and the Other States	102
13.	Massachusetts Blue Cross Income Restrictions--Ward Plan	106
14.	Massachusetts Blue Cross--Monthly Rates	106
15.	Schedule of Payments--Michigan Hospital Service	111

List of Tables (Continued)

Table Number	Title	Page Number
16.	Schedule of Payments--California Physicians' Plan	114
17.	Year of Establishment and Rate and Amount of Sick Benefits Paid by Eleven Unions	134
18.	Claims, Examinations, and Average Period of Weekly Disability of Insured Members in Locals of the International Ladies' Garment Workers' Union, 1935-1938	139
19.	Insurance Company Medical Policies, 1941	150
20.	Combined Group Insurance Statistics of Eight Leading Carriers, 1933	152
21.	Estimated Cash Benefit Payments for Sickness in United States in 1935 Through Voluntary Insurance Plans	153
22.	Complete Insurance for Employees	174
23.	New England Telephone and Telegraph Company Cash Benefits for Accident and Sickness	186
24.	Batchelder and Snyder Company Inc--Benefits and Costs	208
25.	Services Performed Under Medical Care Program of the Kentucky Dam T. V. A. Project, 1940-1941, on Thirteen Hundred and Eighty Employees	222
26.	Stanocola Plan--Disbursement of Revenues 1936-1942	250

List of Tables (Continued)

Table Number	Title	Page Number
27.	Stanocola Employees' Medical and Hospital Association Inc. Statement of Work by Year from January 1, 1925-December 31, 1931	253
28.	Number of Persons Eligible for Care under Prepayment Medical Care Organizations and Number of Physicians and Nurses Associated With Such Organizations by Type of Organization. (Based on Two Hundred and Fourteen Organizations Furnishing Data in 1943)	258
29.	Number of Prepayment Medical Care Organizations Having Specified Membership Restrictions by Type of Organization (Based on Two Hundred and Fourteen Organizations Furnishing Data in 1943)	260
30.	Number of Persons Eligible for Specified Services Under Prepayment Medical Care Organizations (Based on Two Hundred and Fourteen Organizations Furnishing Data in 1943)	263
31.	Comparison of Forty Weighted Plans by Types and Qualities	268 269 270
32.	Eligibility and Coverage of Forty Weighted Plans	288
33.	Administration of Forty Weighted Plans	289
34.	Financial Arrangements of Forty Weighted Plans	290
35.	Scope of Service of Forty Weighted Plans	291
36.	Quality of Care of Forty Weighted Plans	292

List of Tables (Concluded)

Table Number	Title	Page Number
37.	Total Weights of Forty Plans	293
38.	Summary of Weights of Forty Plans	294

List of Sample Forms

Form Number	Title	Page Number
1.	Introduction Form	296
2.	Medical History--Male Form	296
3.	Medical History--Female Form	297
4.	Questionnaire	297
5.	Diagnosis Form	298
6.	Tuberculosis Form	298
7.	Death Record	299
8.	X-Ray Record	299
9.	Record of Personal Voluntary Health Examination	300
10.	Classification Report	301
11.	Employees Certification for Payment Form	301
12.	Sickness Record	302
13.	Report of Sickness Disability	303
14.	Appointment Request	304
15.	Weekly Report upon Sick or Injured Employee	304
16.	Physician's First Certificate	305
17.	Attending Physician's Supplementary Certificate	305
18.	Request to Leave Home	306
19.	Report of Return to Work	306
20.	Report of Accident	307
21.	Initial Report of Accident to Employee	308

List of Sample Forms (Concluded)

Form Number	Title	Page Number
22.	Final Report of Accident to Bell System Employee Occurring in Course of Employment	308
23.	Referral Form	309
24.	Medical Opinion Form	309

MEDICAL INSURANCE IN INDUSTRY

CHAPTER I

MEDICAL INSURANCE - INTRODUCTION

A. Purpose of Thesis

1. Analysis, Evaluation, Investigation, and Comparison of Medical Insurance Plans

The primary purpose of this thesis is to investigate and evaluate the various types of Medical Insurance Plans. An analysis of the plans with particular attention to their advantages and disadvantages should provide valuable material for groups initiating or contemplating revision or reorganization of plans. An objective study of individual plans should establish a valid basis for evaluating and comparing them. The plans investigated and the basis of evaluation will be discussed later.

2. Recommendations

Recommendations as to the requisites of a good future plan (1) will be made after some existing typical plans have been discussed.

B. Need for Medical Insurance

1. Extent and Cost of Invalidity

The need for medical insurance is obvious. In fact, illness and disability constitute one of the greatest single

(1) See Page 280

causes of economic insecurity and dependency. The national income is unevenly distributed so that at all times from one third to two thirds of the families have incomes of an amount which does not permit a standard of living in accordance with decency and adequacy.(1) Low incomes and sickness are found in the same families at a rate which exceeds by many times the sickness rates in the higher income families. In 1943 one billion man days were lost to the war effort because of sickness, three billion dollars in wages were lost, and four and one half billion dollars were spent for medical care.(2) Of this latter amount, seventy five per cent was received from the families receiving the care, twenty per cent from taxation, and five per cent from industry and private philanthropy.(3) On any average day, two per cent of the working population are disabled by illness and seven to nine days per year are lost by males and eight to twelve by females.(4)

These figures show the extent of sickness and the amount that must be paid to cover medical expenses. Extreme variations make sickness a non-budgetable emergency as long as the individual must deal with it out of his own resources. Unfortunately the incidence of sickness varies inversely with

(1) Linford, Alton A., "Should Social Security be Extended Further into the Fields of Medical Care and Hospital Service?" Central Health Council, Boston, Mass. 1944, Page 1.
(2) Ibid Page 1
(3) Ibid Page 1
(4) Millis, Harry Alvin, "Sickness and Insurance", University of Chicago Press, Chicago, Ill., Page 3

family income and the quantity of medical care received varies directly with family income. This is shown by Table 1 on this page, which indicates that the well to do receive more service than the less well to do, that the proportion of illness in which no service is received is greater in the lowest income group, and that the lowest income group receives more of some services than the second lowest group because the former receives more free care and has more sickness. Forty seven per cent of those

TABLE 1

Expenditure for Medical Care and Volume of Services Received According to Economic Status

Survey Covering 8600 White Families 1928-31	Family Income					
	under $1200	$1200-$2000	$2000-$3000	$3000-$5000	$5000-$10,000	$10,000 and over
I. Average expenditure for medical care per family per year	$ 43.17	$ 61.67	$ 90.57	$ 134.06	$ 234.61	$ 506.21
II. Services per 1000 individuals A. Physician, home, office, and clinic calls	1932.0	2046.0	2297.0	2741.0	3621.0	4734.0
B Hospitalized cases	59.4	52.4	59.4	63.1	79.3	98.0
C Days of hospital care	928.0	667.0	757.0	604.0	840.0	1201.0
D Health examinations	83.2	68.0	69.1	82.2	121.7	234.0
E Immunizations	68.5	49.2	50.9	59.6	84.3	120.2
F Per cent of illness receiving service of any type	66.5%	77.0%	80.4%	81.4%	89.0%	92.7%

Source - Reed, Louis S., "Health Insurance - The Next Step in Social Security", Harper and Brothers, Publishers, New York, 1932, Page 27

drafted in the first World War had some defect or disease and twenty one per cent were rejected.(1) In World War II about forty per cent were rejected.(2) This is but one of the many evidences of the results of the lack of adequate medical care. Table 2 on page 5 shows the total expenditures for medical care in the United States in 1929, the particular service purchased, and the source of funds. As can be seen from this table the total per capita expenditure for medical purposes per person in 1929 was thirty dollars and eight cents.(3) At any given time more than two per cent of the population are disabled by sickness(4) and many more have serious illnesses and need medical care. Approximately two thirds of the wage earning families have one or more cases of serious illness every year.(5) About ninety per cent of the wage earning families have medical bills which amount to six per cent of the workers' income.(6) As the burden is unevenly distributed, families are often reduced to poverty because of it. These examples are sufficient to indicate the urgent need for increased medical coverage and aid in sharing the financial burden thereof.

The causes of this large amount of sickness include infection, personal neglect, poor environment, poor working conditions, undernourishment, inadequate clothing, poor housing,

(1) Millis, Harry Alvin, op. cit., Page 9

(2) Interview with Dr. Harry C. Solomon, Chief Psychiatrist at Induction Center

(3) Falk, I. S.; Rorem, C. Rufus; Ring, Martha D. "The Costs of Medical Care", University of Chicago Press, Chicago, Ill., 1933, Page 9

(4) Millis, Harry Alvin, op. cit., Page 10

(5) Ibid, Page 10

(6) Ibid, Page 10

TABLE 2

Total Expenditures for Medical Care in the United States in 1929 in Thousands of Dollars

Service	Total Expenditures (1)	Source of Funds				Per Capita 1929(2)
		Patients (1)	Government (1)	Philanthropy(1)	Industry (1)	
Physicians in private practice	$1,090,000	$1,040,000			$50,000	$$8.97
Dentists in private practice	$ 445,000	$ 445,000				$ 3.66
Secondary and sectarian practitioners	$ 193,000	$ 193,000				$ 1.59
Graduate nurses private duty	$ 142,000	$ 142,000				$ 1.17
Practical nurses private duty	$ 60,000	$ 60,000				$ 0.49
Hospital operating expenses	$ 656,000	$ 278,000	$300,000	$ 54,000	$24,000	$ 5.40
Hospitals new construction	$ 200,000	$	$100,000	$100,000		$ 1.64
Public health	$ 121,000		$ 93,500	$ 27,500		$ 1.00
Private lab laboratories	$ 3,000	$ 3,000				$ .02
Orthopedic and other supplies	$ 2,000	$ 2,000				$ .02
Glasses	$ 50,000	$ 50,000				$ .41
Drugs	$ 665,000	$ 665,000				$ 5.47
Organized medical service	$ 29,000	$ 7,790	$ 16,000	$ 210	$ 5,000	$ 0.24
TOTAL	$3,656,000	$2,885,000	$509,500	$181,710	$ 79,000	$30.08

Sources - (1) Committee on the Costs of Medical Care for the American People, "Final Report", Publication Number 28, Page 14

(2) Falk, I. S.; Rorem, C. Rufus; Ring, Martha D.; "The Costs of Medical Care", University of Chicago Press, Chicago, Illinois, 1933, Page 9

inadequate medical and nursing care, overwork, etc. The problem of improving the situation can be approached from the point of view of prevention, adequate medical, surgical, hospital and nursing care, and compensation through money benefit. It is the purpose of this thesis to show how these objectives can be accomplished through insurance, both cash benefit and medical.

2. Existing Provisions for Medical Care

In 1932, one million people were providing medical service, one half in private practice.(1) The comparative income of physicians and other professional men in 1936 which is shown on Table 3 on page 7, indicates that physicians are not overpaid. In 1939 there were seven thousand hospitals with more than one million beds, over sixty nine per cent of which were in government institutions as can be seen from Table 4 on page 7, which indicates the capacity of hospitals according to control and type of service. Fees were on a sliding scale according to the income of the patient. Gradually private group clinics began to be established and offer complete medical service for fixed periodic payments. The first of these was that established by Doctors Allan Ross and Harry Clifford Loos in Los Angeles in 1929.(2) The growth and development of this and similar plans will be discussed later, but first it might be well to look further into the present status of medical insurance.

(1) Millis, Harry Alvin, op. cit., Page 29
(2) Ibid, Page 34

TABLE 3

Annual Incomes of Various Professional Groups 1929 in Dollars

Professional Group	Arithmetic Average	Median
Physicians		
Committee on Cost of Medical Care Study	$5304	$3827
American Medical Association Survey (1928)	$6354	$4900
Dentists	$4575	$3781
Lawyers	$5888	
Clergymen	$2653	
Mechanical Engineers		$4100
College Teachers		$3200
Yale Faculty	$4701	$4000
Professional and Scientific Personnel in the Employment of the U. S. Government		$3100

Source - Reed, Louis S., "Health Insurance, The Next Step in Social Security", Harper and Brothers Publishers, New York, 1937, Page 129

TABLE 4

Bed Capacity According to Control and Type of Service 1936

	Nervous and Mental		Tuberculosis		All Others		Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Government	529,464	96.4%	58,953	80.0%	175,423	37.0%	763,840	69.7%
Private Non-Profit	10,375	1.9%	11,570	15.7%	253,929	53.6%	275,874	25.1%
Private Profit	9,113	1.7%	3,169	4.3%	44,725	9.4%	57,007	5.2%
TOTAL	48,952	100.0%	73,692	100.0%	474,077	100.0%	1,096,721	100.0%

Source - Reed, Louis S., "Health insurance, The Next Step in Social Security", Harper Brothers Publishers, New York, 1937, Page 159

C. Present Status of Medical Insurance

1. Public Attitude and Investigations

It is interesting to note the general attitude of the public as evidenced by a poll sponsored by Fortune Magazine. The results of this poll are shown in Table 5 below.

TABLE 5

Fortune Poll on Public Attitude

	Should	Should Not	Don't Know
Medical Care for everyone who needs it.	74.3%	21%	4.7%

Source - Medical Care, "Fortune's Poll on Medical Care", Vol. 2, No. 3, June, 1942, Page 284

As can be seen, the large majority of people polled favored complete coverage. Unfortunately the situation today is far from this goal. The evident need for increased medical care as shown by the sickness and mortality rates for the poor in large cities is as high today as it was fifty years ago. (1) Ten years ago, Health Insurance was an issue and it was claimed that the agitation was due to the depression. Five years ago rising prosperity was named by some as the cause. Today it is the political situation and tomorrow it will be the unrest after the war. (2) However it is fairly evident that the movement for increased medical insurance is not a passing fad and that something

---

(1) The U. S. Interdepartmental Committee to Coordinate Health and Welfare Activities, "The Nation's Health", U. S. Government Printing Office, Washington, 1939, Page 5
(2) Ibid, Page 5

will be done. As evidence of the interest in this subject, the studies of the costs of illness and distribution of medical care, the national and state conferences, and articles on medical economies in professional journals might be cited.

2. Present Day Plans and Policies

In 1932, thirty two states and the District of Columbia authorized Hospital Insurance plans with the result that seventeen million are now insured in the United States against hospital bills.(1) Medical plans started later, largely as a defense against government control, and now exist in thirteen states and cover about one million persons.(2) Industrial health plans serve eighteen million people.(3) These and government plans, private association plans, medical society plans, cooperative plans, insurance company plans, labor organization plans, etc. will be taken up later. It is evident though, merely from the number of different plans existing and their coverage, that some progress is being made. The government should take, and is taking, some part in supplying adequate medical care because the individual's health is just as much a matter of social concern as is his life, education, old age pensions, employment, etc. However, medical insurance should not necessarily be completely controlled by the government as will be shown in Chapter II.(4) Most medical insurance plans, both government and voluntary,

(1) Sinai, Nathan "Present Status of Health Insurance in the United States", American Journal of Public Health, Vol. 34, No. 2, February, 1944, Page 108
(2) Ibid, Page 108
(3) Fishbein, M., "Medical Insurance Plans-Which System Will Guarantee the Best Medical Care", Vital Speeches, Vol. II, No.1 January 1, 1945, Page 191
(4) See Page 40

operate on the group practice principle in order to be able to increase their use of modern facilities. Group practice also helps the coordination of general practitioners and specialists, the economy of practice, the reduction of overhead, and the increasing of the division of labor, etc. Medical insurance is compulsory in many foreign countries but has not yet reached that stage in this country although there is much agitation for a compulsory plan as will be seen later.(1) At present the United States is in a period of trial and error in the medical insurance line but has progressed considerably as is evidenced by the fact that more medical care is received by the insured than by the non-insured.(2) The reason for this is probably that because the insured is compelled to pay contributions, he tries to get the greatest possible profit out of the common fund, especially if the relations are depersonalized. This situation could be remedied by letting the insured know that a certain part of his contributions are reserved for him personally and that sums expended by him are kept in an individual account of which the balance will come to him later. Sweden and France have recognized this principle and in these countries part of the charge is borne by the patient at the time the service is given.(3) The International Association of Physicians approves of the principles of Medical Insurance but demands free

(1) See Page 40
(2) Decourt, H. Ferdinand, "The Abuses in Sickness Insurance", Handbook of Sickness Insurance, American Medical Association, 1935, Page 13
(3) Handbook of Sickness Insurance, "Critical Analysis of Sickness Insurance", American Medical Association, 1935, Page 47

choice of doctor and control of all phases of medical service by the physician.(1) The American Medical Association's point of view on the subject is well expressed in the following excerpt from a report approved by the House of Delegates of the Association in 1935:

> "There is nothing inherently good or bad from a medical point of view in different methods of collection. Insurance, taxation, budgeting, advance financing, and all other methods are nothing more than tools with which to conduct an economic transaction. They remain nothing more than this and can be discussed impartially if they are kept strictly within the economic sphere. The problem is to select the best method for every purpose. The chief thing to keep in mind is that all forms of collection should be isolated from any control of service and be kept exclusively in the economic field."(2)

The present status of Medical Insurance might be different if this principle were followed. There has been great progress in medical care in the last fifty years but little in increasing its coverage and making the cost more bearable.

D. Development of Prepayment Plans

1. Origin and Growth of Different Types of Plans up to 1920

The prepayment principle began with the forming of mutual benefit societies and was developed shortly before the Civil War for the employees of hazardous industries such as mining, lumbering, and railroading in areas remote from other medical facilities. The state of Washington in 1911 required that

---

(1) Handbook of Sickness Insurance, op. cit., Page 47
(2) Ibid, Page 48

employers compensate their workers for loss of earnings.(1) A Medical Aid Act was passed in Washington in 1917 whereby employers and employees were to contribute equal amounts to defray the cost of medical care for industrial accidents.(2) Many groups of employers gradually increased their share of the contributions and began to finance medical service for all injuries regardless of origin. Hospital Associations and clinics provided medical care and later medical service bureaus were established by county medical societies. The first group practice clinic was that established by Doctor William Mayo in 1887 and the first prepayment clinic, which offered medical care whenever required in return for periodic payment of a fixed sum by individuals, was the Ross-Loos Clinic in Los Angeles. The latter was started in 1929.(3) In a few cases, industries themselves established and financed programs requiring no contributions from the employees even when their dependents were included. Perhaps the outstanding example of this type of prepayment plan is that of the Endicott Johnson Corporation of New York, which offers comprehensive medical service to all of its nineteen thousand employees and includes physicians' services, hospitalization, nursing, dentists' services, etc. This costs the corporation twenty-five dollars and ninety cents per person but is provided free of charge to the employee.(4) More frequently

---

(1) Bureau of Research and Statistics, "Prepayment Medical Care Organizations", Federal Security Agency Social Security Board, Memorandum No. 55, Page 1
(2) Ibid, Page 1
(3) Ibid, Page 1
(4) Millis, Harry Alvin, op. cit., Page 39

employees set up their own medical care plans and form mutual Benefit Societies. The Stanocola Employees Medical and Hospital Association (1) is a good example of this type. The employees have their own clinic with seven physicians and charge two dollars per member and three dollars per family. (2) Much more prevalent are joint employer employee plans to the support of which the employer and employee contribute varying amounts.

2. Development Since 1920

In the 1920's and 1930's, groups of physicians operating private clincis began to furnish medical care on a prepayment basis. Consumer sponsored plans, fraternal organizations, unions, and cooperative associations would employ physicians to take care of their members. State medical societies utilized the administrative facilities of hospital service plans and offered service. (3) The Michigan Medical Society established a medical insurance plan in 1939 and California did likewise in 1940. (4) All these plans had the objective to effect a balance between medical charges and services by pooling risks and costs, minimizing overhead, and assuring regular incomes for practitioners. Among the problems common to all plans are certification of disability, supervision, rate and method of remuneration of physicians, extensions of benefits to all persons of low income, coordinating of community health service, etc. Insurance company

---

(1) See Page 246
(2) Reed, Louis S., "Health Insurance, The Next Step in Social Security", Harper Brothers, New York, 1937, Page 189
(3) Bureau of Research and Statistics, "Prepayment Medical Care Organizations", Federal Security Agency, Social Security Board, Memorandum No. 55, Page 4
(4) See Pages 110, 113

plans do not offer medical care but do offer cash payment. Unions have recently begun to consider protecting the health of their workers as their province as evidenced by the plans of the Amalgamated Clothing Workers, The Brotherhood of Locomotive Engineers, the Printing Pressmen's Union, the Stereotypers and Electrotypers Union, the Phototypers Union,(1) and the International Ladies' Garment Workers' Union.(2)

It might be well to determine the nature of medical insurance plans, now that the need for them and their development has been made clear.

E. Features of Medical Insurance Plans

1. Important Questions

The merits or defects of medical insurance should not be judged on the success or failure of any individual plan but detailed studies should be made of many plans. Perhaps the three most important questions to ask when studying any plan are the following:

1. "Do all employees without discrimination receive medical care which is adequate in quality and quantity?"

2. "Can patients purchase all medical care they need at a price they can afford to pay?"

3. "Do physicians receive fair remuneration?"(3)

---

(1) Millis, Henry Alvin, op. cit., Page 37
(2) See Page
(3) Goldman, Franz, "Prepayment Plans for Medical Care", Joint Committee of the Twentieth Century Fund and Medical Administrative Service Inc., New York, 1941, Page 11

2. Main Characteristics

a. Origin and Development

The aim of prepaid medical insurance is to make costs predictable, budgetable, and bearable. As described above, the auspices of the plans are many and varied, ranging from plans sponsored and paid for entirely by an industrial company, including plans to which both the employer and the employee contribute, to plans in which the employee pays the whole cost, and to plans sponsored by insurance companies or medical societies. The origin of the various plans and their course of development are interesting to note.

b. Eligibility and Coverage

The various plans also differ in eligibility and coverage. Some plans have restrictions in regard to age, income, employment, and health status, and others have no restrictions.

c. Administration

Administration is another factor to be considered. Some of the plans are run exclusively by people other than the beneficiaries whereas in other plans the latter are represented.

d. Financial Arrangements

Financial arrangements constitute another big source of variance, both in regard to the amount and methods of collection and the paying of the physician. Many plans have surcharges for extra services as night calls, X-rays, Specialist services, etc. The sample operating statement for a medical care plan in Table 6 on Pages 16, 17, and 18 is interesting

and should be studied by those starting a new plan or reorganizing an old one. It indicates the large number of sources of income and expense that must be considered.

TABLE 6

Form Used for Analysis of Costs-Sample Operating Statement

Income

"I. Operating Income

A. Income from Subscription (Advance Payments)
  1. Application Fees
  2. Special Entrance Examination Fees
  3. Periodic Prepayments
  4. Special Assessments

B. Income from Extra Charges in Case of Sickness

  5. Diagnostic Procedures
  6. Special Treatment Methods
  7. Hospitalization
    a. Room and Board
    b. Additional Charges
  8. House Calls
  9. Night Calls
  10. Drug Sales
  11. Appliance Sales
  12. Ambulance Service
  13. Care of Family Dependents
  14. Others

II. Non-Operating Income
  15. Interest and Dividends from Investments
  16. Temporary Funds (Loans)
  17. Permanent Funds
    a. Capital Stock
    b. Grants and Donations
  18. Others

TABLE 6 (Continued)

Expenses

I. Direct Operating Expenses

- A. Expenses for Salaries, Wages, Services, and Supplies Directly Related to the Care of the Sick
    1. Physicians' Salaries
    2. Dentists' Salaries
    3. Pharmacists' Salaries
    4. Outside Doctors' Remuneration
    5. Nurses' Salaries
    6. Laboratory Technicians' Salaries
    7. X-Ray Technicians' Salaries
    8. Ambulance Service
    9. Auto Expenses for Doctors
    10. Auto Expenses for Others
    11. Medical and Surgical Supplies
    12. Clinical Laboratory Supplies
    13. X-Ray Laboratory Supplies
    14. Drugs and Medicines for Patients
    15. Appliances for Patients
    16. Hospitalization
        - a. Room and Board
        - b. Extras
    17. Insurance
        - a. Mal Practice
        - b. Workman's Compensation
        - c. Auto Liability

- B. Expenses for Physical Plant and Current Maintenance (excluding major replacements)

    18. Rent, Clinic
    19. Fuel, Clinic
    20. Gas, Electricity, and Water Clinic
    21. Telephone and Telegraph Clinic
    22. House Cleaning, Clinic
    23. Laundry, Clinic
    24. Insurance, Clinic
    25. Miscellaneous

- C. Major Replacements

    26. Replacements
        - a. Buildings
        - b. Sanitary Equipment
        - c. Medical and Surgical Equipment, Instruments and Apparatus
        - d. Expenses for Administration

TABLE 6 (Continued)

27. Rent, Fuel, and Light, Office
28. Salaries and Wages, Business Office
29. Stationary and Printing
30. Postage and Freight
31. Telephone and Telegraph, Office
32. Sundry Supplies
33. Others such as Auditing, Fidelity Bonds, etc.

II. Indirect (Non-Operating) Expenses
    34. Interest on the Invested Capital
    35 a. Ground
        b. Building and Equipment
        c. Rent
    35. Interest on Debts
    36. Amortization
    37. Taxes

III. Depreciation
    38. Building
    39. Sanitary Equipment
    40. Medical and Surgical Equipment, Instruments and Apparatus
    41. Linen, Clothing
    42. Other Equipment of Household."

Source - Goldman, Franz, "Prepayment Plans for Medical Care", Joint Committee of the Twentieth Century Fund and Medical Administrative Service Inc., New York, 1937, Page 54

e. Scope of Service

Perhaps the biggest distinguishing feature of a plan is the scope of service which varies considerably from plan to plan. Some plans offer only cash benefits. Others began in 1929 to offer hospital service only. The Associated Hospital Service of New York is the largest group hospital plan.(1) Most of these plans offer hospitalization for a limited period of time and services up to a predetermined

---

(1) Goldman, Franz, op. cit., Page 11

limit. There are also physicians 'service' plans as the Michigan Medical Service, (1) which offers surgical benefits and sometimes medical service. Complete coverage of a combination plan is naturally the most desirable. The Ross-Loos Medical Group of Los Angeles (2) combines group practice and voluntary health insurance. This was organized in 1929 at the request of the Los Angeles Department of Water and Power, and now has more than eighty physicians and twenty three thousand subscribers. (3) It provides medical service in the home, clinic, and hospital; laboratory service, including examination and physical therapy; hospitalization, to ninety days; ambulance; drugs and dressings, etc.

Determining the fees to charge and the scope of service to offer is not as easy as one might at first think. The following must all be carefully considered: Social and economic factors in the groups served by these plans, sex and age distribution, income, methods of estimating costs of medical care program, overhead, medical expense and indirect expense, differences in health status of members, average number of clinic and home visits, effect of health examinations upon the cost of illness, increased demands, ratio of physicians to potential patients, relation of size of group served to costs, average costs of hospital care, average expenditures, percentage of various groups hospitalized, frequency of hospitalization,

(1) See Page 110
(2) See Page 126
(3) Goldman, Franz, op. cit., Page 13

average length of stay, charges for care, average costs of drug supply, average costs of administration, expenditures excluding depreciation, cost to patients, etc.(1)

Among other services a plan with complete coverage would offer: physician's care at clinic, hospital, and home; periodic health examinations; maternity services; specialist services; dental care; nurses' care; clinical, X-ray, and physical therapy services; drugs; anesthetics; dressings; appliances; hospitalization; ambulance service; house calls; home nursing, etc.

f. Quality of Care

Quality of care is another differentiating factor. It is hard to judge this as most plans which do offer service offer good service. However, there are indications that the service offered varies with geographical areas. In Washington and Oregon the contract system, with physicians' care and hospitalization to which the employer does not contribute, seems to be prevalent.(2) In California, employer-owned hospitals supported by deductions from wages are numerous.(3) Small industries in the Rocky Mountain District contract with independent hospitals at a fixed rate per employee for non-industrial medical care. This area includes Ohio, Montana, Nevada, Arizona, New Mexico, Utah, Colorado, and Wyoming.(4)

(1) Goldman, op. cit., Page 21
(2) Williams, Pierce, "The Purchase of Medical Care Through Fixed Periodic Payments", National Bureau of Economic Research, New York, 1932, Page 10
(3) Ibid, Page 10
(4) Ibid, Page 11

In the Central interior coal fields of Iowa, Kansas, Missouri, Oklahoma, Arkansas, Indiana, Illinois, and Kentucky, physicians are engaged by the company to render first aid, and independent hospitals contract with the Coal Miners' Union for other services.(1) In the Lake Superior Mining Regions in Minnesota and Michigan, there are many hospitals owned by the companies and operated by physicians under contract to them. In the Appalachian Coal Region of Pennsylvania, Ohio, Kentucky, Tennessee, Maryland, Virginia, and Alabama, the companies contribute to the health of their workers and deductions are made from the employees' wages.(2) In Georgia and other southern textile industry states, the company pays most of the fees.(3) Of course it is to be understood that none of these systems appear exclusively in any of the above areas. They have merely been noticed to be in existence in fairly large numbers there. Physicians' Service and hospitalization seem to be more prevalent in the west and medical indemnity in the east.(4) Again it must be emphasized that this is just a coincidental factor noticed in research.

F. General Medical Opinions

1. Committee on Costs of Medical Care

The findings and the conclusions of the Committee on the Costs of Medical Care in 1932 are interesting in that they

(1) Williams, op. cit., Page 11
(2) Ibid, Page 13
(3) Ibid, Page 17
(4) Davis, Michael, "America Organizes Medicine", Harper and Brothers, New York, 1941, Page 147

represent the opinion of most of the members of the medical profession today and serve as the impetus for much of the current movement. This committee represented Doctors, Public Health Men, Dentists, Hospitals, Druggists, Scientists, and the public, and so clashed of opinion resulted. Both the majority and the minority reports agreed on the following points:

"1. The Need for Medical Service of the best quality and its general availability.

2. Doctors and other professional persons should be adequately remunerated.

3. Doctors must be adequately represented on control and policy boards and have control of professional questions.

4. Public Health Service must be strengthened.

5. The government should provide needed medical care not only for veteran soldiers, sailors, indigents, and inmates of certain institutions, but also for those afflicted with certain diseases as T.B. and for the mentally diseased.

6. Grants in aid should be made to provide needed doctors, hospitals, and nurses in thinly populated and remote areas with limited financial capacity.

7. Medical care and certification of insured persons for sickness benefit should be completely divorced."(1)

The Committee on the Costs of Medical Care decided in 1932 that the population was divided with reference to

(1) Millis, op. cit., Page 37

income as is Table 7 below.

TABLE 7

Division of Income 1932

Class	Income	Per Cent of Population (Approximation)
Rich	$5000 and over	9%
Upper Middle	$2000-$5000	35%
Wage Earning	$1000-$2000	41%
Indigent	Below $1000	15%

Source - Faxon, Nathanial W., "Health Insurance Plans", Lecture at Harvard Medical School, February 2, 1945

The cost estimates for complete medical care have varied from twenty-five dollars and thirty cents to sixty-six dollars per individual per year.(1) It is with regard to the wage earning forty-one per cent that most of the controversy concerning group versus individual practice has arisen.

The majority group of the committee on the Costs of Medical Care were for group practice and prepayment.(2) This thesis deals only with examples of prepayment and group practice plans as means of insuring against sickness. Franz Goldman has described Group Medical Practice as "The application of medical service by a number of physicians working in systematic association with joint use of equipment and technical personnel and with centralized administrative and financial organization."(3)

(1) Faxon, Nathanial, W., "Health Insurance Plans", Lecture at Harvard Medical School, February 2, 1945
(2) Millis, op. cit., Page 126
(3) Goldman, op. cit., Page 5

All the plans offering medical service described herein have this and the prepayment principle as their basis.

2. Individual Opinions

a. Senator Leverett Saltonstall

It is interesting to note that Senator Leverett Saltonstall, in a speech before the Suffolk Medical Society, November 18, 1944, said that he hoped that we could do without government interference in the medical problem and that the more we do without the government, the more we can keep the government as we want it. (1) He went on to say that in Massachusetts, sixty million dollars is spent annually for health purposes by the government without exercising any restrictive controls over the medical profession. (2) Among others, veterans may obtain free medical care at government expense. The ex-governor complimented the medical profession for the great contribution they are making toward keeping the people of the state healthy and thus better able to work. It can be seen that not all government officials favor government control of Medical Insurance.

b. Dr. Roger Lee

At this same meeting, Dr. Roger Lee, President of the American Medical Association, gave a good verbal picture of the conditions of Health Insurance. He pointed out that Health Insurance is the wrong term to use and that actually

(1) Saltonstall, Leverett, Speech before the Suffolk Medical Society, November 18, 1944
(2) Ibid.

we are looking for Sickness Insurance.(1) He indicated that although most people think that both cash benefit and medical service are offered by most plans, actually the former is more prevalent as evidenced by such plans as that adopted by the state of Rhode Island in conjunction with its unemployment compensation plan(2) or by the plans of insurance companies.(3) One reason for this is the inability to define illness precisely and to obtain an accurate actuarial basis for calculation of rates. If applied to a homogenious group like students in a school, the insurance principle seems to work well, but when families are included the rates of sickness seem to be more unpredictable. Dr. Lee indicated that although the Blue Cross(4) has done much, it has been unable to include chronic diseases, acute conditions, fractures, etc. because of the inability to predict the frequency of such occurrences.(5) Medical societies offer plans limited to obstetrics and surgery(6) which can be defined explicitly and predicted with a reasonable degree of accuracy. Much experimentation is necessary before complete medical care can be offered universally on the prepayment basis. However, much has been done in this line as will be seen by the plans discussed in the central portion of this thesis. Dr. Roger Lee

---

(1) Lee, Dr. Roger, Speech before the Suffolk Medical Society, November 18, 1944
(2) See Page 49
(3) See Page 148
(4) See Page 102
(5) Lee, Dr. Roger, op. cit.
(6) See Page 109

pointed out that in most countries where compulsory government Medical Insurance is in existance, politics has entered too much into the picture and the death rate has been lowered less than in the United States. (1) He advocates the keeping of the problems of poverty and sickness separate and opposes government control of Medical Care which he thinks should be left in the hands of the medical profession. (2) This is the general opinion of the medical profession as a whole and will be discussed at greater length in the chapters devoted to government and medical society insurance plans. (3) Suffice to say now that experiments are in existance and are being watched closely by those interested in the problems of Medical Insurance. Before discussing specific plans, it might be well to consider the ideas of a few more medical experts.

c. Dr. Charles Willinsky

In a talk before the Health Council of Boston and the Boston Health League on March 8, 1945, Dr. Charles F. Willinsky pointed out that Disraeli said one hundred years ago that "the health of the people is the concern of the state." (4)

d. Dr. Elmer Bagnell

At this same meeting, Dr. Elmer S. Bagnell expressed the opinion that organized medicine as represented by the societies is too conservative, (5) and that the cause of the failure of the Massachusetts White Cross Plan was inadequate

---

(1) Lee, Dr. Roggr, op. cit.
(2) Ibid
(3) See Chapters II and III
(4) Willinsky, Dr. Charles, "Proposed Plans for Medical Care", Speech before the Health Council of Boston, March 8, 1945
(5) Bagnell, Dr. Elmer S., "Proposed Plans for Medical Care", Speech before the Health Council of Boston, March 8, 1945

preparation. He favored federal subsidizing in the form of grants-in-aid for unusual diagnostic costs, catastrophic illnesses, and the indigent, but emphasized that different states have different needs.(1) Dr. Bagnell opposed universal compulsory tax-supported medical care and indicated that under such a system contact with the individual is apt to be on a political basis.(2) He also indicated that he believes the Health Council is against government compulsion except in the case of major hazards and when it has been demonstrated that private enterprise cannot handle the situation.(3)

e. Dr. Alan Butler

Dr. Alan Butler at this same meeting emphasized that the cost sharing principle must be accepted and that the crucial problem is whether compulsion is to be used or not.(4) He agreed with the conclusion of the Committee on Costs of Medical Care that if a third party pays it would be necessary to alter the structure of medical practice from an individual fee for service system to an integrated group practice plan providing for control of the quality of service. He expressed the opinion that we will have both voluntary and compulsory medical insurance.(5) Dr. Butler also indicated the self-protective attitude of the American Medical Association and the fact that there actually was compulsion in the 1870's when the

(1) Bagnell, op. cit.
(2) Ibid
(3) Ibid
(4) Butler, Dr. Alan, "Proposed Plans for Medical Care", Speech before the Health Council of Boston, March 8, 1945
(5) Ibid

Marine Hospital was financed by payroll deduction. He pointed out that as this tax placed American shipping at a disadvantageous competitive position it was later replaced by a general tax. Dr. Butler advocated a central policy deciding agency with operations being controlled on the local level (1) as in LaGuardia's scheme. (2)

In a lecture at Harvard Medical School, March 9, 1945, Dr. Butler urged that a change be accomplished by "evolutionary not revolutionary processes," (3) and that health should be a concern of the government whose funds already help support research, education, hospitals, etc. He repudiated the American Medical Association's suppression of changes and progress, and favored such a plan as LaGuardia's. (4) He indicated that the American Medical Association originally even opposed federal subsidy of medical schools and that it is a reactionary body which gives little opportunity for expression of minority opinion, that it dominates the state societies, that it misinterprets the English system, and that it is fighting a delaying action. (5) Dr. Butler agreed with the Pepper Committee that we should admit that there is room for improvement, i.e. that the cost is great and cannot be paid when the service is rendered. He also said that we should admit that the distribution is uneven, that government help

(1) Butler, op. cit.
(2) See Page 44
(3) Butler, Dr. Alan, Speech at Harvard Medical School, March 9, 1945
(4) Ibid
(5) Ibid

is necessary, and that we should adjust to present conditions.(1) Dr. Butler expressed the opinion that the principles of the Wagner-Murray-Dingell Bill(2) are good although the Surgeon General is given too much power and the advisory committee too little.(3)

f. Dr. Nathanial W. Faxon

Dr. Nathanial W. Faxon likewise indicated that "it's time for a change" because the doctors feel that the quality of care could be improved and the people feel that expenses could be reduced. He advocated the adoption of a broad, comprehensive plan such as that of The Committee of Twenty-Nine Doctors whose proposals are discussed later in this thesis,(4) but suggested that it might be wise for us to follow a middle of the road policy at present, neither rushing into anything nor holding back, especially as there are so many government agencies already caring for the sick. Among these are the Departments of Public Health; Public Hospitals; the United States Public Health Service; Veterans', Army, Navy, and Marine Hospitals; Tuberculosis and Mental Hospitals; the Children's Bureau; Homes for Crippled Children; Emergency, Maternity, and Infant Relief Hospitals; and Workmen's Compensation.(5) He indicated that the big weakness of the Wagner-Murray-Dingell Bill is its administration, not its ideas.

(1) Butler, op. cit.
(2) See Page 61
(3) Butler, op. cit.
(4) See Page 277
(5) Faxon, Dr. Nathanial W., "Proposed Plans for Medical Care", Speech before Health Council of Boston, March 8, 1945

Dr. Faxon suggested that the advisory council mentioned in the bill should have power to tell the Surgeon General what to do and that he should do what he is asked to do just as the President of the United States should carry out Congress's laws.(1) Dr. Faxon said that the real control is in the continued education of physicians in schools and through grants, fellowships, etc. Dr. Faxon believes that the existing agencies should be supplemented, not replaced.(2)

It can be seen from the above opinions that even physicians realize that some changes are necessary. That much progress has been made can be seen from the discussion of the various plans throughout the thesis.

One important aspect of the problem of "Medical Insurance in Industry" which seems to be neglected by most writers on the subject is that of educating the public. Many who are convinced of the advantages of being insured in advance against illness proceed to abuse the privilege. The public should definitely be educated as to the principles of "medical insurance in industry" in order that voluntary plans may work successfully.

Most thinking people agree that medical care is costly; that sickness is unpredictable as to occurrence, frequency, and length; that hospitals and doctors are unevenly divided; that more medical care, both preventive and curative,

(1) Faxon, op. cit.
(2) Ibid

is needed; that medical education should continue after medical school; and that additional research is desirable. The differences of opinion arise as to the method of accomplishing these aims, particularly the administrative control. The various means will be described and compared but no attempt will be made to determine the "best way".

G. Plans to be Discussed and Bases of Comparison

Now that the purpose of this thesis, the need for "Medical Insurance in Industry", the Present Status of Medical Insurance, the Development of Prepayment Plans, the General Features of Plans, and the findings and opinions of various organizations and individuals have been considered, it might be well to mention the plans to be discussed and the basis of comparison of these plans. It should be noted that insurance under the Farm Security Act (1) and Workmen's Compensation Acts (2) will not be discussed herein as this thesis is confined mainly to a consideration of industry's voluntary action in the problem of industrial sickness.

---

(1) The Farm Security Act of 1936 has in it provisions whereby low income farmers may borrow money to pay medical bills. They may also invest in a prepayment plan. The problem of Farmers' Medical Insurance is not directly related to industry so has not been included in this thesis.

(2) The Workmen's Compensation Act insures industrial employees against industrial hazards which occur while they are acting within the scope and in the execution of their employment. Each state has its own act but under these acts, if an employer does not insure, he loses the immunities of the fellow servant rule, voluntary assumption of risk and contributory negligence. The insurance does not insure the worker in the above three cases and so additional insurance is necessary. Workmen's Compensation alone would constitute an entire thesis itself and so has not been included in this thesis.

1. Plans not Sponsored by Industries

First, as regards to the general types of plans considered herein, an affort has been made to discuss a few plans of each of the main different types of Medical Insurance Plans. For the purpose of this thesis, these have been divided into two main classifications--Plans not sponsored by industries(1) and Plans sponsored by industries.(2) Although these will be discussed separately it can readily be seen that they are closely interrelated in their effect on the general problem of "Medical Insurance in Industry". Among the outstanding examples of plans not sponsored by industries which have come to the fore in this country are Local, State, Federal, and Foreign Government insurance plans. The New York City Plan; the Rhode Island Plan; the Model, Standard, and Wagner-Murray-Dingell Bills; and the plans of Denmark, Germany, Great Britain, France, Russia, and New Zealand have been chosen to exemplify government plans.

Voluntary non-profit private association plans as the Blue Cross constitute another category. Closely associated with this type are Medical Society plans, as those in Michigan, California, New Jersey, and Ohio, and Massachusetts; hospital mal-practice insurance plans; group clinic plans as the Ross-Loos Medical Group; and cooperative plans such as that in Tampa, Florida. Labor plans as the International Ladies'

---

(1) See Chapters 2-4
(2) See Chapters 5-8

Garment Workers' Union and others and commercial insurance company plans, as that of the *Prudential Life Insurance Company* constitute a third general classification of non-industrial plans that will be discussed.

2. *Plans Sponsored by Industries*

There are many different types of plans sponsored more or less directly by industries and their employees. These can be divided into three general classifications according to sponsorship, (a) Non-Contributory Plans financed by the company, (b) Joint Employer-Employee Plans, and (c) Employee Plans. Each of these can be subdivided into cash benefit and medical service plans. The plans which will be used as examples of these types are as follows:

Non-Contributory Cash Benefit Plan--*The New England Telephone and Telegraph Company*

Non-Contributory Cash Benefit and Hospitalization and Surgical Benefit Plan--*Boston Edison Company*

Non-Contributory Medical Service Plans--*Endicott-Johnson Company*, *American Cast Iron Pipe Company*, *American Tobacco Company* and *American Suppliers Inc.*, *Paraffine Company*

Joint Employer-Employee Cash Benefit Plans--*Batchelder and Snyder Company*, *General Electric Company*

Joint Employer-Employee Medical Service Plans--*Binghampton New York Companies*; *Consolidated Edison of New York*; *Tennessee Coal, Iron, and Railroad Company*; *Tennessee Valley Authority*; *Henry J. Kaiser Company*

Employee Cash Benefit Plans--William Filene's Sons Company;
Lynn Riverworks of General Electric; American Bosch Company,

Employee Medical Service Plans--Stanocola, Colonial Beacon Oil Company.

Knowledge of details of these plans together with a few other miscellaneous plans will give the reader an idea of the various methods of solving the problem of medical insurance. There is no one best plan as all of them have their good and bad points.

3. System of Weighting

It is not easy to make a comparison of these plans because of their lack of uniformity. They differ in auspices, origin and development, eligibility and coverage, administration, financial arrangements, scope of service, and quality of service, as well as in other features. Hence an attempt will be made to rate each of these features separately on an arbitrary basis of twenty points each. Although all the plans will have similar final ratings, weights, or scores, the component parts of each plan will be rated differently. An expert could then assign proportionate weights to each feature and readily determine, with the aid of the results of the investigations made in preparing this thesis, which plan is the best and why. For example, if Plan "A" receives weights of fifteen, ten, twenty, twenty, twenty respectively for

eligibility and coverage, administration, financial arrangements, scope of service, and quality of care, and Plan "B" receives twenty, fifteen, fifteen, fifteen, twenty, both plans would receive a total of eighty-five. The qualified medical expert might decide that for his purpose, scope of service was worth sixty points and each of the other features ten points and give Plan "A" sixty out of sixty for the scope of service and thirty-two and one half out of forty for the other items, making a total of ninety-two and one half for Plan "A". By the same token, Plan "B" would receive a rating of eighty and be the less desirable of the two according to the expert although both plans received an original rating of eighty-five. This system of weights should provide an easy way of rating plans and be useful in studies made to determine what type of plan to adopt under certain circumstances.

4. Desirable and Undesirable Features

There are many features which make a plan more or less desirable. Following are a few of each category:

a. Desirable Features

1) Group payment decreases individual financial burdens.

2) Individual research is more productive because doctor is assured of income.

3) If doctor is paid in advance he does not have to be lenient in regard to fakers in order to keep a patient.

4) Cash benefit insurance provides against loss of income.

5) The employee feels he is contributing and not accepting charity.

6) A reserve for emergencies is created in advance.

7) Curative medicine can be emphasized.

8) Hospital benefits are received by many who otherwise would not receive them.

9) Dependents receive benefits under many plans.

10) Complete medical service is offered on the basis of prepayment.

11) A choice of physician can still be maintained.

12) The cost is spread over many people.

13) Personal relations may be preserved.

14) The standards of medical care are raised.

15) Greater income is received by more physicians.

16) Home service and free examinations and lab service are provided.

17) The cost of absence caused by sickness is met.

18) In non-contributory plans, the pressure by dominant groups for special favors is eliminated as is the necessity of keeping everyone satisfied.

19) Some benefits to many are possible.

20) Employees sometimes appreciate insurance from a fund to which they have contributed more than insurance given to them for nothing.

21) The cost of sickness becomes definite.

22) The financial responsibility is not the company's under an insurance company plan. The risk is with the carrier. Increased coverage reduces the risk. Restrictions are impersonalized.

23) Less absenteeism and better work results because of relief from worry.

24) Adequate clinical and hospital facilities are made available.

25) Efficiency increases.

26) Employee loyalty is improved.

There are many arguments favoring insurance but the above provide a sufficient sample.

b. Undesirable Features

1) Insurance compels haste and hinders diagnosis.

2) Private practice is hindered.

3) Close personal relations between patient and physician are destroyed.

4) Bureaucracy is encouraged.

5) The family doctor principle of "from each according to his means and to each according to his need" is destroyed.

6) Malingering is encouraged.

7) Doctors will incur needless costs.

8) The operation of plans are burdensome to industry.

9) Individuality is cramped.

10) Free choice of physician and patient is hindered.

11) Preventive features are often excluded.

12) There are too many exclusions from eligibility.

13) Service is too limited.

14) Hospital plans do not provide for physicians' care.

15) The cost to industry is too high.

16) Over medication is encouraged.

17) The burden of cost falls on the low income class, those least able to afford it.

18) Medical care of the indigent is omitted.

19) Graduate education is not encouraged.

20) Hospitals practice medicine.

21) Treatment becomes mechanical.

22) Medicine becomes a political issue.

23) Under the Wagner plan too much power is in the hands of the Surgeon General.

24) Surgical and obstetrical care is the only service offered in many plans.

25) There are salary limitations.

26) There is a danger of impersonal injustice.

27) Delay occurs.

28) The cost is high.

29) The patient is not represented on the management boards of most plans.

30) The service may be spread thin.

31) There is a lack of medical participation in the administration.

32) The physicians have too many patients.

33) Charges are made for extra services.

34) Colored people are excluded in many southern plans.

As mentioned before, because each plan has so many different features it is practically impossible to compare the plans on an absolute basis point for point. Hence an

attempt has been made in the following chapters to show the main provisions of samples of the various types of plans and to generally compare these plans on the basis of eligibility and coverage, administration, financial arrangements, scope of service, and quality of care. In the conclusion, besides summarizing the results of the research and comparing the plans and indicating the present situation, an attempt will be made to forecast the future and make recommendations.

At this point it might be well to turn to the discussion of government plans for medical insurance and other plans not sponsored by industries and then those sponsored by industries.

CHAPTER II

LOCAL, STATE, FEDERAL, AND FOREIGN GOVERNMENT INSURANCE PLANS

A. Arguments For and Against Government Insurance

Perhaps the most controversial problem in the field of Medical Insurance is that concerning government control and, as its final solution will have an important effect on all industries, it is worth considerable attention in any treatment of "Medical Insurance in Industry". The doctors, hospitals, insurance companies, industries, and others with vested interests quite naturally oppose government interference with what they consider their province. Some socially minded people favor government control and believe it is the only way to meet the need for the necessary increased medical coverage described in Chapter I of this thesis. (1) There is no answer to this controversy as there are arguments on both sides. It would be well to examine some of these at this point, keeping in mind that the principle underlying compulsion is the "assumption of an economic need and the inability of the individual to provide for that need" (2) without legislation to spread the risk and cost.

(1) See Page 1

(2) Commonwealth of Massachusetts, State Advisory Council of the Division of Employment Security, "Repott on Sickness Benefits", Wright and Potter Printing Company, Boston, Mass., November 1, 1945, Page 16

1. Arguments for Government Insurance

Some proponents of government medical insurance say that protecting the health of the people is the responsibility of the government and can only be accomplished adequately by taxation, the money from which should be used to provide cash disability benefits, to replace losses due to disability, to provide medical care with the cooperation of the medical profession, and to expand the Public Health Service. (1) Others feel that the government can control undesirable practices resulting from competition as reducing fees to the point of impairing service in order to attract patients, underpaying and overloading physicians, utilizing premiums for profits, and restricting the scope of service. They further contend that often those in poor health avail themselves of the opportunity of joining voluntary groups and that those in good health abstain. If the voluntary plan excludes the bad risks it excludes those most in need. Furthermore a large proportion of the nation's families do not have the income required to purchase voluntary health insurance. (2) Others just above the poverty line will not voluntarily use their few extra pennies to insure against an illness that might not occur. Often those families which do not have enough income to buy voluntary insurance are excluded by income limitations. (3)

---

(1) Linford, Alton A., "Should Social Security Be Extended Further into the Fields of Medical Care and Hospital Service?" Massachusetts Central Health Council, Boston, Mass. 1944, Page 4
(2) Falk, I. S., "Security Against Sickness", A Study of Health Insurance", Doubleday, Doran and Company, New York 1936 Page 323
(3) Linford, op. cit., Page 3

A compulsory government plan will cover these people with incomes just above the minimum level of subsistance,(1) and will increase the number of people served and reduce the cost. Often voluntary insurance has been exploited as a means of making the worker pay part of the cost of industrial accident insurance and so some government regulation is probably necessary even under a voluntary plan, especially because the indigent sick must be cared for.

In opposition to voluntary insurance is the claim that philanthropic organizations cannot be expected to provide the solution, that commercial insurance companies charge too much, that fraternal orders do not have a wide enough appeal and do not offer good enough service or adequate pay to the doctors, and that trade union sick benefits funds are too small.(2) There are many other arguments used in favor of government control of medical insurance but the above can serve as an example. Perhaps the main justifications of government compulsion are: "(1) that the function is essential to the control of general welfare, and (2) that it is not in the public interest to restrict the function to private enterprise."(3) Government insurance can be effected by making the purchase of insurance compulsory or by the government's underwriting policies or both.

---

(1) Falk, op. cit., Page 324

(2) Williams, Pierce, "Alternatives to Compulsory Health Insurance", Annals of the American Academy of Social and Political Science, Vol. 170, November, 1933, Page 128

(3) Commonwealth of Massachusetts, State Advisory Council of the Division of Employment Security, op. cit., Page 16

2. Arguments for Voluntary Insurance

Those favoring voluntary insurance claim that it can be established for small units of population wherever homogeneous groups exist, that it may be adapted strictly to the needs and the financial circumstances of those it serves, and that it need not be of one particular type in one place just because it is so in another.(1) The direct contribution by the consumer reminds him that it is a mutual undertaking, discourages malingering, and helps avoid political interference and control. Some opponents of government insurance believe that a deterioration in medicine will result if every doctor is on salary from the government or on a panel. They further contend that the existance of funds does not necessarily produce doctors in parts of the country that seem less desirable as fields of medical practice.(2) Many think that compulsion will curtail individual initiative. Bureaucracy is feared by a great number of the proponents of the voluntary insurance. Industries do not relish the idea of the additional burdens which would be imposed by compulsory insurance. Under government insurance, the doctors would have to be lenient in order to keep their patients. However it must be realized that the government already is spending huge sums of money in caring for persons who have reached helplessness through conditions

(1) Falk, op. cit., Page 323
(2) Houser, Gerald F., "Should Social Security be Extended Further into the Fields of Medical Care and Hospital Service." Massachusetts Central Health Council, Boston, Mass. 1944 Page 8

of disease and could well expand public health as a supplement to voluntary insurance. Each state made its own workmen's compensation laws so if the government does enter into the field of medical insurance there is no reason why it could not do so locally. Also the fact that no scheme will suit all parts of the country equally well, because the standards of living vary from place to place, is another argument in favor of voluntary insurance. Many of the proponents of voluntary insurance are not averse to assistance from the government as long as control remains in the hands of qualified physicians. In fact, they favor the physicians' being remunerated for their care of the poor by taxing the entire community. Hospitals could likewise be helped by government support.(1)

Thus it appears that the main argument in favor of government insurance is that its coverage would be much wider than that of voluntary insurance plans. On the other hand, it could not easily be adapted to the many different existing situations and might necessitate too much control over the physicians.

B. Local Plan--New York City

There are government insurance plans on the local, state, and national levels. Some of these are in operation but most of them are merely under consideration. Mayor LaGuardia's plan for New York City is a good example of a proposed local plan.

(1) Williams, Pierce, op. cit., Page 138

1. Origin and Development

The poor were getting good medical and surgical care free in city clinics and hospitals in New York and the rich were paying for it. In between poor and rich, there was a group which dreaded the economic horror of sickness and had to beg, borrow, or steal money in order to meet the costs of illness. In fact thirty per cent of the money borrowed at high interest rates in New York in 1943 was used to pay the expenses of family illnesses.(1) Thus the need for some plan was evident. Realizing the need for increased medical coverage and having the insurance plans in Great Britain, France, Russia, Germany, Denmark, and New Zealand(2) as examples, New York City began thinking about a city plan. Dr. J. Stanley Kenney, former president of the New York County Medical Society said,

> "We visualize for New York City, and ultimately for the entire state, a type of insurance which will be more all inclusive, efficient, and sound than any which has ever been devised before. It should place much emphasis upon preventive medicine as well as upon curative medicine, and should aim to bring about a high degree of physical fitness. It will have to include all modern diagnostic services."(3)

This is indeed an imposing objective but its accomplishment is not impossible. La Guardia favored a Compulsory National Plan as the Wagner-Murray-Dingell Bill(4) to a local voluntary plan

(1) La Guardia, F. H., "Sunday Broadcast to the People of New York City", April 30, 1944, Page 2
(2) See Pages 71-94
(3) La Guardia, op. cit., Page 7
(4) See Page 61

but offered his local plan as a first step. There already exists in New York several private plans which the Mayor proposed to consolidate. Among these are the Associated Hospital Service Plan, the International Ladies' Garment Workers' Union Plan (1) and the Consolidated Edison Company Plan. (2) None of these is all embracing and none takes in the entire family and provides complete medical and surgical care throughout the year, the objective of the La Guardia New York City Plan.

2. Eligibility and Coverage

It would be well to examine some of the provisions of this proposed New York City Plan, the origins of which have just been indicated. In regards to eligibility, membership in the plan will be open to all persons who live or work within the city of New York. It will be open to aommercial and industrial corporations, to labor unions, fraternal organizations, or any group existing for any purpose other than to join the plan. The protection will be available to everyone who earns up to $5000 a year and will include the family. (3)

3. Administration

As to general non-medieal administration, a non-profit corporation will be formed and be governed by a Board of Directors composed of outstanding representatives of all sections of the community. It will be entirely non-political and will be responsible for the management of the affairs of the corporation. There will also be a medical board which

(1) See Page 135
(2) See Page 214
(3) La Guardia, op. cit., Page 13

will be responsible for the quality of medical treatment and service, research, and ethics and practice of the profession. The open panel system will be used if approved by the physicians. Under this plan any qualified doctor who wishes may join. The patient will have a wide choice of doctors and the fees which he pays will be pooled and later divided among the doctors. Supervision and control of avoiding bad practices, abuses, and other bad habits is to be left to the medical profession. If closed panels are preferred by the medical profession, this is provided for under the plan. Units will consist of seventy general practitioners, seven maternity specialists, fifteen children's specialists, ten surgeons, eight eye, ear, nose and throat specialists, and others covering a zone of about one hundred thousand people. Salaries would range from six thousand to twenty thousand dollars.(1)

4. Financial Arrangements

As to financial arrangements affecting the consumer, the total charge will be approximately four per cent of the employee's wages, at least half to be paid by the employer and the balance by the employee.(2) Employees' contributions will be deducted from their pay checks and paid over to an insurance fund with the employers' contributions. The latter is deductable as a business expense from state and federal taxable income. The employer may pay more than fifty per cent if he so chooses.

(1) La Guardia, op. cit., Page 15
(2) Ibid, Page 14

5. Scope of Service

Perhaps the most important matter in any plan is the amount of service offered. This plan covers normal and catastrophic illnesses and includes services of general practitioners at home, office, or hospital; specialist services for all treatments and necessary consultations; diagnostic, X-ray, and laboratory service; surgery (major and minor); every kind of operation; maternity care, (pre-natal and post-natal care for mother and child); child care, (immunizations, feedings, etc.), preventive care, (examinations, visiting nurse service); and all hospital services.(1)

6. Conclusions

This plan is one of the best plans offered by any agency. Its eligibility provisions are sufficiently broad to allow most of the needy people to become members. The medical profession wanted it to be limited to the indigent sick, those earning eighteen hundred dollars per year or less,(2) but the group of people who earn between twenty-five hundred and five thousand dollars is in need of and will receive this kind of protection also. The physicians have a say in the medical administration of this plan. Some plans do not cover all members of the family or are limited as to kind of illness or are only for operations or hospital service. This plan provides "skilled medical care for office and home treatment with surgical and specialized help and all necessary auxiliary

(1) La Guardia, op. cit., Page 14
(2) Ibid, Page 12

services for serious catastrophic illness and major operations."(1) The quality of service should be excellent if the physicians are chosen as planned. On the basis of twenty points each for eligibility and coverage, administration, financial arrangements, scope of service, and quality of care this plan should receive a weight of one hundred. Of course, actions speak louder than words and so the plan cannot really be judged until it is studied in action. The La Guardia Plan is still in the form of a proposal and has not yet been acted upon, although many similar but less inclusive plans are in existance in New York.

C. State Plan--Rhode Island

1. Origin and Development

Now that a city plan has been covered briefly, it might be well to consider a state plan. Rhode Island is the only state that has a state wide plan of medical insurance. The state administrators recognized that a person who is sick and therefore out of work is badly in need of income and hence they have inaugurated a compulsory Sickness Insurance Law. This is not a medical service plan as such in that it does not include any preventive or curative features or offer services or payment for services. It is a cash benefit program providing insurance against loss of income because of sickness.

2. Eligibility and Coverage

Eligibility for benefits is limited to persons who

(1) La Guardia, op. cit., Page 12

have been away from their jobs at least two weeks. Originally individuals receiving workmen's compensation or payments from their employers were excluded from cash sickness benefits, However, by an amendment made in 1943 the exclusion was lifted so that now the worker can receive more income while sick than working and malingering is prevalent. A return to the original idea is now being advocated.

3. Administration

The Rhode Island Plan is administered by the unemployment compensation board. The act authorizing this plan was passed three weeks after it was proposed because it involved no new contribution from the worker nor any new forms to be filled out by the employer. It merely involved additional bookkeeping by the Unemployment Compensation Board.

4. Financial Arrangements

The plan is not subsidized but supported entirely by employee contributions. In 1942 employees contributed to the unemployment compensation fund one and one half per cent of their wages and employers three per cent.(1) This produced a large reserve and so it was suggested that two thirds of the employees' contribution be shifted to a sickness fund. Consequently on June 1, 1943, the employees' contribution to the Unemployment Compensation Fund was reduced to one half per cent and one per cent was set aside for sickness.(2)

---

(1) Close, Katheryn, "Money While You're Sick", Survey, Volume 79, Number 12, December, 1943, Page 329
(2) Ibid, Page 329

This constituted the entire source of revenue. Administrative expenses were limited to one per cent of the amount collected.(1)

5. Cash Benefits

As for the benefits under this plan; during the first week of illness, the waiting period, there are none. The benefits of the second week are payable on the third. Each claimant must see a doctor within five days of the onset of the illness and once a week thereafter until he returns to work. There is no physical examination required but a physician's statement must accompany the application for benefit. The benefit is based on credits built up during the proceeding year, the weekly amount being related to the highest quarterly wage in the previous year. The duration depends on the length of the illness and the amount of wages earned the previous year. Existence of other income is not a consideration. By a recent amendment, the head physician determines how long the claimant is expected to be laid up and sets up the benefit period. If more money is needed an examination must take place to determine the necessity. Also a medical board reviews the doctor's certifications and examines questionable clients.

6. Conclusions

As for the results of this plan, during the first seven months of its operation twenty-two thousand people received

---

(1) Commonwealth of Massachusetts, State Advisory Council of the Division of Employment Security, op. cit., Page 2

benefits. The first was a machinist, Tom Brown, on April 10, 1943.(1) By November 1, 1943, one hundred and forty-six thousand, one hundred and forty-three checks had been issued to twenty-two thousand one hundred and forty-five persons for two million, three hundred and twenty-four thousand, nine hundred and forty-six dollars and eighty-three cents, and the cash reserve had been raised to two million, eight hundred thousand dollars.(2) However, an increase of the employee's contribution to one and one half per cent and the amount of money for administrative purposes to three per cent was requested as was the denial of benefits to employees receiving other compensation. More money should be had for administration, for local examinations, and for a study of voluntary programs in the United States and abroad, and more money is necessary to pay benefits, partially because of the increased number of ailments brought on by wartime tension. Although this plan is far from perfect, it is an example of an attempt to remedy the alarming situation of inadequate medical care.

For eligibility and coverage, this plan should receive a weight of fifteen out of twenty. The waiting period of one week restricts the coverage and eliminates those who are sick for less than a week. Its administration is in the hands of the Unemployment Compensation Board and the patient is not represented. (Fifteen points). The financial arrangements seem

---

(1) Close, op. cit., Page 335
(2) Ibid, Page 335

adequate and worth twenty points. The benefits, since medical service is not offered nor is cash payment to cover medical bills, are only worth ten points. The quality of the service is normal as in private practice (twenty points) making a total of eighty points. It must be understood that these weights are purely arbitrary and used merely to provide a basis for comparison. Anyone who wishes may change the relative weights and still have a basis for comparison.

It is interesting to note in closing the discussion of the Rhode Island Plan that there is need for a rise in payments because of the increased familiarity of workers with their rights, the physical and mental effects of overwork during the war periods, payments to claimants who are receiving workmen's compensation, and payments to claimants for full duration of pregnancy.(1) However, as shown above, the administrators are working on all these problems and have suggested remedies as physical examinations to establish the validity of claims, restrictions of beneficiaries, and increase of premiums. Of course a state plan cannot alter provisions and give special remedies as can private plans serving smaller groups, but this Rhode Island plan is well worth investigating as to date it is the only state-wide compulsory medical insurance plan in existance. As will be shown below, this does not mean that other states are not seriously considering plans. However, it is

(1) Commonwealth of Massachusetts, State Advisory Council of the Division of Employment Security, op. cit., Page 32

still often true that "actions speak louder than words." It is hard to judge whether or not proposed plans will work well in practice. So, although the Rhode Island Plan has administrative and financial faults and does not offer medical service, it has contributed much toward the ultimate solving of the problem of "Medical Insurance in Industry".

D. State Medical Insurance Proposals and Investigations

1. New Hampshire

New Hampshire is one of the few other states which has had proposed legislation regarding a medical insurance plan. In 1939 the legislature created a Commission on Disability Benefits which in 1941 submitted a report recommending a compulsory system to be financed by a one per cent employee contribution and to have a two per cent limit on administrative expenses, a one week waiting period, and rates and duration of benefits based on total annual earnings ranging from six dollars to eighteen dollars a week and payable for eighteen weeks. (1) In 1944 a bill was introduced by the Manufacturers' Association of New Hampshire proposing that the state set up minimum standards or set up a plan of its own. (2) This suggestion indicates another form of "voluntary compulsion" which could be applied and it will be interesting to watch further developments of this type which

---

(1) Commonwealth of Massachusetts, State Advisory Council of the Division of Employment Security, op. cit., Page 24
(2) Ibid, Page 25

might well be able to meet the problem and obviate the necessity of federal legislation. As this proposal is not a complete plan worked out in detail, it will not be discussed further or weighted.

2. Massachusetts

In Massachusetts, there is no state medical insurance plan but the State Advisory Council of the Division of Employment Security has recently investigated the possibility and desirability of paying benefits under the Employment Security Law to employees who are absent from work on account of sickness. In canvassing public opinion, this State Advisory Council found that manufacturers feared the excessive burden of taxation which would place them at a disadvantage with employers in other states, that insurance companies questioned the actuarial expendiency of action under present conditions, that labor was divided, and that the medical group feared regimentation by bureaucracy.(1) The council also indicated that the"existing unemployment compensation machinery for the collection of contributions, the filing of wage record data, and the payment of claims are considered to be readily adaptable to similar functions under a disability program."(2) However, the Council also found that some means of checking the authenticity of illnesses as by medical certifications would have to be introduced and that the social security board

(1) Commonwealth of Massachusetts, op. cit., Page 25
(2) Ibid, Page 28

would have to be reimbursed for utilization of unemployment compensation and machinery. Also, if the insurance were extended to domestics, farm laborers, and the entire working population, a flat premium and benefit based on salary ranges would have to be imposed because the insurance principle of basing payments on wage data at source would not apply.(1)

Under present conditions the amount of tax necessary to finance and administer a state plan would be difficult to estimate unless the provision of medical care be considered a separate problem applicable to the entire population and be financed separately. Considering all these factors the lack of transferability of insurance when changing jobs and the extent of voluntary insurance plans in the state, the council, although it realizes the desire for an extension of facilities and aid in meeting the costs, does not feel that government compulsion in Massachusetts is essential especially in view of the fact that high taxes already are imposed on most employees and that physical examinations would probably result and restrict employment. Thus the council recommended "continued study of the subject matter into more normal times when answers to some of the unknown factors may be forthcoming and when better judgments may be made as to whether private enterprise in Massachusetts has met the challenge for even better and quicker progress in this field than heretofore."(2)

(1) Commonwealth of Massachusetts, op. cit., Page 28
(2) Ibid, Page 46

Before discussing the federal bills for medical insurance it might be worthwhile to consider very briefly one more proposal for state action, the Model Bill.

E. The Model Bill

1. Eligibility and Coverage

The Model Bill of the American Association for Social Security proposes a statewide system of compulsory health insurance covering all employees subject to the state's jurisdiction, except those engaged in other than manual labor receiving more than sixty dollars a week and farm laborers and domestic servants in households having less than three servants.(1) Employees are eligible if they have been employed ten days during the three preceding months and after termination of employment are eligible for one fifth of the number of days they have been insured during the past five years.(2)

2. Administration

This plan is to be administered by the commissioner of health and local councils. The practitioners may be remunerated by salary, per capita, or fee.

3. Financial Arrangements

The cost, six per cent of the payroll, is to be borne jointly by employers, employees, and the state. The employers are to contribute three and one half per cent of the wages if

---

(1) Reed, Louis, "Legislative Proposals for Compulsory Health Insurance", Law and Contemporary Problems, Volume VI, Number 4, Autumn, 1939, Page 628

(2) Ibid, Page 628

they are twenty-two dollars or less, two and one half per cent if they are between twenty dollars and forty dollars, and one and one half per cent if over forty dollars and the employees are to contribute one per cent, two per cent, and three per cent at these wage levels, the total being four and one half per cent, which when added to the state's contribution of one and one half per cent makes six per cent.(1)

4. Scope of Service

One hundred and eleven days of hospital care for one illness are given, the first twenty-one being free and the rest being offered at fifteen per cent of the cost. General practitioner care is given for twenty-six weeks and specialist care for twelve weeks.(2) Cash benefits are provided for each day of wage loss due to disability, after a waiting period of five days, at fifty per cent of full time wages with a maximum of fifteen dollars a week plus three dollars for a dependent spouse and one dollar and fifty cents for each child if the employee has worked one hundred and four days during the preceding year.(3) Cash benefits are provided for one hundred and fifty-six days in fifty-two weeks. Three fourths of the six per cent is for medical care and one fourth for the disability and maternity benefits, the latter being for six weeks before and six weeks after the child's birth.(4) There is also a provision for insuring the self-employed with incomes under sixty

---

(1) Reed, op. cit., Page 629
(2) Ibid, Page 630
(3) Ibid, Page 630
(4) Ibid, Page 631

dollars at three and three eighths per cent of their income and those on relief.(1)

5. Conclusions

The eligibility and coverage should receive a weight of fifteen because of occupational and service restrictions. The administration should only receive ten points as neither the doctor nor patient have any say in it. The financial arrangements are satisfactory and worth twenty points. The scope of service is complete and worth twenty, and the quality of service should be good and is worth twenty, making a total of eighty-five.

F. The Standard Bill

1. Origin and Development

Agitation for a national compulsory health insurance act in the United States is not a new issue. In December, 1912, the American Association for Labor created the National committee on Social Insurance which in 1915 drafted "The Standard Bill".(2) The second and third drafts of this bill appeared in 1918. It was not passed, however. In 1917 there were investigating committees in eight states. This American movement was due to the British Insurance Act of 1911 which in turn was based on the German model.

(1) Reed, op. cit., Page 631
(2) Millis, op. cit., Page 118

2. Eligibility and Coverage

All manual laborers earning under one hundred dollars a month were to be insured through fraternal orders, trade unions, mutual benefit associations, or local territorial funds.

3. Financial Arrangements and Cash Benefits

Benefits were to be extended to dependents and to amount to two thirds of the insured's wages and to continue for twenty-six weeks. The employer and the insured were to contribute forty per cent each and the state twenty per cent.(1)

4. Conclusions

This plan was opposed by organized insurance businesses, medical associations, druggists, patent medicine manufacturers, Christian Scientists, employer organizations, and the executive council of the American Federation of Labor, and denounced as unnecessary, socialistic, and unAmerican. It was claimed that it would beget malingering, involve contract medicine, reduce the income of doctors, destroy the close relations between the doctors and the patients, and discourage medical research.(2) Thus the first period in the American Health Insurance Movement ended. However, the seeds were planted and soon grew into the "Wagner-Murray-Dingell Bill".

(1) Millis, op. cit., Page 120
(2) Ibid, Page 120

G. Federal Plan--The Wagner-Murray-Dingell Bill

1. Origin and Development

The proposed Wagner-Murray-Dingell Bill, HR 2821 and S 1161 of 1944, a plan for national compulsory medical insurance, has caused much controversial comment throughout the country.(1) Before discussing the merits of this "cradle to the grave" bill, it would be well to see how it originated and what its provisions are. Organized labor through the Committee on Social Security of the A. F. of L. was responsible for the less comprehensive Elliot Bill of 1942 in which the C. I. O. cooperated.(2) Senator Wagner agreed to introduce the new bill and asked the Social Security Board to aid in drafting it. When introducing the bill on June 3, 1943, Senator Wagner said,

> "There is no plan here such as that lately considered in Britain for a system of socialized medicine with all doctors required to be salaried employees of the government. Unlike this British Proposal, my bill assures complete freedom of choice of doctor and hospital by the patient and freedom of medical practice and remuneration for the doctor and the hospital. No doctor is forced into the insurance system or forced on a salary status. Arrangements for obtaining medical laboratory, or hospital care would be essentially as they are now in this country except that payment for the care and services would be out of the insurance fund built up through the insurance premiums paid by the individual and his employer. Voluntary hospitals would of course be eligible to participate in the plan if they chose to do so and thus be enabled to expand their splendid community services. Non-profit group medical or

---

(1) On May 24, 1945 a new Wagner-Murray-Dingell Bill with substantially the same provisions as the old one described below was introduced to Congress and tabled.

(2) Medical Care, "Origins of the Wagner Bill", Volume 14, Number 1, February, 1944, Page 5

> hospitalization plans may also be utilized in carrying out the program and they would be in a position to offer supplementary health protection for families desiring more than the basic social insirance benefits guaranteed under the bill. In all its provisions this bill would promote the personal relations between the doctor and the patient and be adopted to the needs and practices of the individual and community in both rural and urban areas. Similar basic principles as to medical and hospital benefits and freedom of medical practice are embodied in a program recently put forward by the government of Canada with the full accord of the Canadian Medical Association and the Canadian Hospital Council."(1)

This introduction seems to answer many of the objections to the bill but the bill must be examined to see if these ideals are carried out in it.

2. Eligibility and Coverage

As to eligibility and coverage, every employee in the country is eligible without exception.

3. Administration

The bill proposes joint administration with the Unemployment Compensation Program, cash payments for loss of wages because of illness, administration of the permanent disability benefits under the Old Age and Survivors Insurance Program, and administration of the medical care program by the Surgeon General of the United States.(2) This last feature seems to be the most controversial aspect of the whole bill. According to section 903a and 903b of the bill,

---

(1) Congressional Record - Senate, June 3, 1943, Page 5344
(2) Commonwealth of Massachusetts, State Advisory Council of the Division of Employment Security, op. cit., Page 19

> "The Surgeon General of the Public Health Service is hereby authorized and directed to take all necessary and practical steps to arrange for the availability of the benefits provided under this title and of services and reports required by the Social Security Board in the determination of disability. The Surgeon General is hereby authorized to negotiate and periodically to renegotiate agreements or cooperative working arrangements with appropriate agencies of the United States or any state or political subdivision therein and with other appropriate agencies and with private agencies or institutions and with private persons or groups of persons, to utilize their services and facilities, and to pay reasonable and equitable compensation for such services and facilities and for the trust fund to receive reimbursements for services rendered with respect to individuals in circumstances under which benefits are not authorized under this title, and to negotiate and periodically renegotiate agreements or cooperative working arrangements for the purchase or availability of supplies and commodities necessary for the benefits provided under this title, and after approval by the Social Security Board to enter into contracts for such services, facilities, supplies, and commodities."(1)

Section 901c says that the Surgeon General must notify the advisory board of these obligations and secure authorization for disbursements from the trust fund. Section 904a establishes a National Advisory Medical and Hospital Council consisting of the Surgeon General and sixteen members appointed by him from names submitted by professional organizations and agencies and others informed on the need for medical, hospital, or related benefits. Each member is to receive twenty-five dollars per day plus travelling

(1) HR 2861 78th Congress Section 901a and 901b and 901c

expenses while attending meetings of the council or doing business for it.(1) It is to advise the Surgeon General in regard to professional standards of quality to apply to medical benefits, designation of specialists, methods to stimulate attainment of high standards, standards to apply to participating hospitals, suitable methods of paying for medical and hospital services, survey of services furnished by practitioners and hospitals, grants in aid for professional education and research, and establishment of special advisory committees.(2) Any physician legally qualified by a state to furnish any services may participate. An individual may select from qualified physicians those from whom he shall receive services except specialist services which are subject to the consent of the practitioner selected. The Surgeon General is to make known to the individual entitled to benefits the names of the practitioners who have agreed to furnish services, the participating hospitals, and the specialists. The job of administration of the plan includes paying practitioners, insuring prompt efficient care of the individuals entitled to benefits, promoting personal relationships between the physician and patient, providing professional and financial incentives for professional advancement and high standards of quality through adequacy of payments and assistance in use of opportunities for professional study, aid in preventing of disease, etc.(3)

---

(1) HR 2861, Section 904a
(2) Ibid, Section 904a
(3) Ibid, Section 904a

4. Financial Arrangements

As for financial arrangements, payments are to be made from the trust fund to medical practitioners on the basis of fees for services rendered to individuals according to a fee schedule approved by the Surgeon General; or on a per capita basis, the amount being according to the number of individuals on the practitioner's list; or on a salary basis; or on a combination approved by the Surgeon General, according in each area as the majority of general practitioners elect.(1) Payments to specialists are likewise to be on salary, per session, fee for service, or per capita. The Surgeon General may prescribe maximum limits to the number of potential beneficiaries for whom practitioners may undertake to furnish general medical care, distribute those individuals who do not select a physician or are refused by one, and establish appeal bodies to determine complaints from individuals entitled to benefits, practitioners, hospitals, etc. The employer pays six per cent of wages and the individual six per cent.(2) This payment includes old age, survivors, disability, unemployment, medical, and hospital insurance. A self-employed person contributes seven per cent of the market value of his services.(3) It should be noted that this would be an increase of five per cent to the workers who now pay one per cent for old age and survivors insurance.(4) Actually

---

(1) HR 2861, Section 904a
(2) Ibid, Section 904a
(3) Ibid, Section 904a
(4) Commonwealth of Massachusetts, State Advisory Council of the Division of Employment Security, op. cit., Page 19

most of the burden would fall on the consumer who is already heavily taxed. It is questionable whether or not the individual could afford this extra tax.

5. Scope of Service

As for the scope of service, the insured will be entitled to general and special medical, laboratory, and hospital benefits. He will be limited to thirty days of hospitalization unless the Surgeon General and the Social Security Board see fit to extend this to ninety days in a particular case.(1) He is not entitled to benefits receivable under a Workmen's Compensation Act.

6. Quality of Care

The quality of service under this plan would probably be excellent, as there are strict qualifications for physicians and adequate facilities.

7. Conclusions

The main objection to the Wagner-Murray-Dingell Plan is that it gives the Surgeon General too much power. Organized medicine through National, State, and Local journals, leaflets, sydicated editorials, and radio addresses have waged a counter campaign against the bill because regimentation of doctors is feared. Commercial drug companies have contributed money to help turn out material saying the bill is an attempt by Washington Bureaucrats to centralize more government in Washington at the expense of the states and destroy private

(1) HR 2861, 78th Congress, Section 901a

practice of medicine and substitute "socialized bureaucratic political medicine under a one man dictator."(1) Some people say the insured would have to go to a doctor assigned by a Washington bureaucrat and that doctors would be placed on a salary and told where to practice and what to treat. It is evident that anyone who would make such a remark has not read the above bill as it specifically states that the patient may choose his physician and that the doctor may choose the mode of payment and does not have to participate unless he so desires.

The eligibility and coverage of the plan cannot be criticized as it covers more people than can possibly be covered by local plans at the present time. Hence on this point a weight of twenty would be correct. As stated above it is the administration which is objected to most. The Surgeon General does have too much power under this plan but not as much as many people think he has. The Social Security Board has custody of the funds. The Surgeon General is appointed for a four year term by the President of the United States and can be replaced. The Surgeon General must consult with an advisory board on most matters. Guiding principles as the following are binding on the Surgeon General: Any physician legally qualified can have his name on the panel; free choice of physician and patient is required; the physicians in each area may decide the method of payment; and the council must approve of

---

(1) Linford, Alton A., "Dispute over the United States Health Insurance Act", Public Affairs, Volume 7, Number 3, June, 1944, Page 163

standards for hospitals and physicians. The executive of any successful organization should have a reasonable amount of power. Thus on the basis of administration this plan should be rated at least ten out of twenty, ten points being deducted becuase there is too much central control. As for the financial provisions of the bill, the six per cent tax on employers and employees one fourth of which is for medical care (1) seems fair, as in 1942 seventy-five per cent of the three and one half billion dollars spent for medical care was paid by individuals. (2) Though fair, this tax is a little too high. A weight of fifteen out of twenty would seem correct for this part of the plan. As to the scope of service anything but a twenty out of twenty would be wrong as complete service is offered. The only exception to this is that the Surgeon General and the Social Security Board are authorized to require the payment by the patient to the physician of a nominal fee so as to prevent abuses and obstacles to needed medical care. (3) This is a wise provision. The quality of care which would be received under the plan is worth twenty points, making a total of eighty-five points for the plan.

Thus this plan with a minimum disturbance of private practice and the complete choice of physician frees the patient and doctor of financial worries. The doctor can still practice in his own office, and the hospital can remain under

---

(1) Linford, op. cit., Page 166
(2) Saturday Evening Post, "Do We Need Federal Medicine?" Volume 216, Number 14, September 25, 1943, Page 112
(3) Linford, op. cit., 166

its present sponsorship. The doctor can choose a fee similar to his present one, will have better use of existing medical facilities, and can afford to locate where he cannot now because of low incomes. Blue Cross plans (1) in forty states only cover seventeen million odd people. Physicians' plans (2) are limited to surgery and obstetrics and one half of the population cannot afford them. Thus some form of government control is probably necessary to provide complete coverage.

It is interesting to watch the opposing factions argue on the subject of government compulsion in medical insurance. On November 27, 1944, in New York City, the National Physicians Committee for the Extension of Medical Service had a conference to promote health insurance run by insurance companies which were represented as were physicians and large businesses but not the consumer. On December 8, 1944, the Physicians Forum met in Washington, D. C. and the consumer, labor, veterans, and business men were represented. (3) As can be seen the former opposes and the latter favors the Wagner-Murray-Dingell Bill. No one knows what the results will be but unless sponsors of voluntary plans act quickly, compulsion is likely to result now that the urgent need for increased medical care has been established so vividly.

---

(1) See Page 102
(2) See Page 109
(3) Survey, "Controversies on Methods of Extending Medical Care", Volume 8, Number 1, January, 1945, Page 20

The American Medical Association opposes National Legislation and favors individual private plans as the Blue Cross (1) and the Blue Shield. (2) Advocates of compulsory insurance say that voluntary insurance plans grow too slowly and will never include everybody and that those who should be protected are not. Nevertheless, compulsory insurance has certain defects as bureaucracy, political intrusion, increased taxes, cumbersome nature, etc. which a voluntary evolution would not entail. However, no decision on which of the two systems is better can be made. Compulsory government systems are discussed in this chapter and voluntary plans will be considered in the next. No matter which plan is finally adopted, many changes are necessary to achieve the common goal. The late President Roosevelt in his message to Congress on the state of the union in January, 1944 and again in 1945, referred to the "right to adequate medical care and the opportunity to achieve and enjoy good health" (3) as essential for an economic bill of rights. Although the Wagner Bill is far from perfect, its opponents go a little too far when they say that "it would destroy the effectiveness of medical care in the country", that "incentive for the physician to become skilled in the art of medical care would be lost", and that "both the quality and

---

(1) See Page 102
(2) See Page 116
(3) Murray, J. E., "Medical Care for All Americans." New Republic, Volume III, Number 2, July 10, 1944, Page 41

quantity of medical care would drastically decline."(1) That this is not so to the extent indicated above may be seen from the discussion of Foreign Government Health Insurance Plans which follows.

H. Health Insurance Plans of Foreign Governments

1. General Description

A discussion of Government Medical Insurance Plans would be incomplete without a consideration of some foreign plans. There is government provision for insurance against sickness in thirty-six countries as follows:

Compulsory: Austria, Belgium, Bulgaria, Chile, Czechoslovakia, Esthonia, France, Germany, Great Britain, Greece, Hungary, Irish Free State, Italy, Japan, Jugoslavia, Latvia, Lithuania, Luxembourg, Norway, Poland, Portugal, Romania, Russia, and Switzerland.(2)

Voluntary: Argentina, Australia, Belgium, Canada, Denmark, Finland, Italy, Netherlands, New Zealand, Palestine, Spain, Sweden, Switzerland, Union of South Africa, and Uruguay.(3)

As can be seen, Belgium, Italy, and Switzerland have both types. The Voluntary Plans are controlled by the state and are available to anyone who chooses to use them.

---

(1) Commonwealth of Massachusetts, State Advisory Council of the Division of Employment Security, op. cit., Page 21

(2) Metropolitan Life Insurance Company, "Health Insurance", Monograph 3, June, 1931, Page 20

(3) Ibid, Page 21

The Danish plan covers a greater proportion of the population than any other compulsory or voluntary plan, fifty-seven and three tenths per cent of the population being covered in 1925. Britain has the highest coverage of compulsory plans and the second highest coverage of all plans, thirty-five per cent, and Belgium comes third with fourteen and three tenths per cent.(1) The dates and approximate number of insured persons in some of these compulsory plans are shown on Table 8 on page 73.

2. Denmark

a. Origin and Development

Denmark's preeminance is attributed to the enforcement of social legislation designed to promote public health and to the large proportion of costs, one third, borne by the state. Employers insist that their employees become insured. The only comprehensive voluntary health insurance plan in force in any country exists in Denmark. In 1892, the government offered state aid amounting to one third the incomes of the existing mutual benefit societies. The number of insured grew from one hundred and twenty thousand in 1885 to two million in 1930, four sevenths of the total population.(2)

b. Eligibility and Coverage

The plan is not limited to workers but insures all

---

(1) Metropolitan Life Insurance Company, op. cit., Page 21
(2) Ibid, Page 18

TABLE 8

Compulsory Health Insurance Plans

Country	Date of Original Law	Approximate Number of Insured
Germany	1883	20,000,000
Austria	1888	2,300,000
Hungary	1891	960,000
Luxembourg	1901	47,000
Norway	1909	600,000
Great Britain	1911	17,230,000
Northern Ireland	1911	360,000
Irish Free State	1911	425,000
Russia	1911-22	8,800,000
Esthonia	1911-22	34,000
Latvia	1911-22	140,000
Roumania	1912	1,000,000
Bulgaria	1918	240,000
Czechoslovakia	1888-1919	2,700,000
Portugal	1919	
Greece	1922-32	Not operating
Yugoslavia	1910-32	610,000
Serb, Croat, Slovene Kingdom	1910-22	
Lithuania	1925	
Italy	1928	New provinces and special groups only
France	1928-30	8,700,000
Netherlands	1929	
Switzerland (Several Cantons)		
Denmark	1933	Partial
Canada		
Alberta	1935	Effective thru referenda
British Columbia	1936	110,000
Japan	1922	2,000,000
Chile	1924	1,240,000
Ecuador	1935	
Peru	1936	

Source - Millis, Harry Alvin, "Sickness and Insurance", University of Chicago Press, Chicago, Illinois, 1937, Page 50

persons whose income exceeds the limits set for members without means to whom alone the state grants are applicable. The plan covers the members' children under fifteen.(1)

c. Administration

State supervision of the subsidized societies is exercised through an inspectorate and failure to conform to its wishes may lead to a refusal of state subsidy. Although recognition is granted to societies only on a trade or territorial basis, the societies may form federations and central unions and a member may change societies, all of which are autonomous.(2) The fact that the state helps subsidize is an important feature of the Denmark plan.

d. Financial Arrangements

Income from members amounts to about sixty per cent of the total, state grants thirty per cent, and interest on investments, voluntary subsidies, contribution of members with means, etc., ten per cent.(3) The state contributes eighty cents a year for each regular insured person, one fourth of the cost of all benefits, and three eighths of the excess of the cost of benefits to persons entering the society with impaired health over the cost of those entering in good health. The remaining three eighths cents is a compulsory charge on the municipality so that the society is entirely compensated for additional expenditure on such members.(4)

---

(1) Metropolitan Life Insurance Company, "Social Insurance Legislation", Monogram Number 4, January, 1932, Page 19
(2) Ibid, Page 19
(3) Ibid, Page 19
(4) Ibid, Page 19

e. Scope of Service

Cash benefits are not to exceed four fifths of the daily wage, nor fall below thirteen cents a day, nor exceed twenty-six weeks a year, nor exceed sixty weeks in three years. They are varied to suit the individual's needs.(1) Free medical attendance and hospital treatment for full members and their children is now provided by law and dental treatment and specialists' services are optional.(2)

f. Conclusions

This plan shows that it is possible to have a voluntary plan on a national scope with good coverage. A rating of twenty out of twenty should be given for the coverage of this plan as everyone is eligible. The administration is checked by the central government and does not represent the employee and so is worth only fifteen points. The financial arrangements whereby the employer, employee, and state share the burden are good and worth twenty. The benefits are limited and hence deserve only fifteen points. The quality of the plan adds twenty more points, making the total ninety.

3. Germany

a. Origin and Development

The plan in Germany serves as a good example of a foreign compulsory medical insurance system. In the early

---

(1) Metropolitan Life Insurance Company, Op. cit., Page 19
(2) Ibid, Page 52

1870's Bismarck said that compulsion was "inevitable and indispensable" and that state subsidies were "advisable".(1) His predictions came true when Compulsory Health Insurance was established in Germany by the act of June 15, 1883 which had for its purpose the building up of a national feeling of gratitude to the state for solving the sickness problem.(2)

b. Eligibility and Coverage

Membership in a health organization was obligatory for wage earners in mines, salt works, metallurgical establishments, quarries, building operations, factories, manufacturing establishments, railroad companies, steamship companies, etc. The coverage was extended in 1892, 1900, and 1903 to commercial employees, clerical workers, and public employees; in 1911 to agricultural workers, seamen, and domestic servants; and in 1923 to education and welfare workers, and nurses so that two thirds of the employed people were members.(3) No sickness benefits were payable to persons over sixty-five.(4)

c. Administration

Funds had to meet certain standards to be accepted as insurance carriers, insurance companies being excluded because they were profit making institutions. Insurance offices supervised the funds and were themselves controlled by

(1) Cohen, Joseph, "Health Insurance, Encyclopedia of Social Sciences, Volume VII, Page 294
(2) Millis, op. cit., Page 57
(3) Ibid, Page 57
(4) Metropolitan Life Insurance Company, op. cit., Page 24

regional insurance offices and the federal insurance office.(1) Until 1943 the plan was governed by an executive board and committee representing the insured and the employer. In 1934 a leader was appointed by a superior officer and the plan began to retrogress.(2)

d. Financial Arrangements

Revenues sufficient to cover operating expenses and reserves had to be collected, two thirds from the insured and one third from the employer. The contributions and benefits were a per cent of the basic wage, six per cent being the maximum.(3)

e. Scope of Service

The benefits included medical care from a physician, specialist care, dentist care, drugs, medical applications, maternity care for twenty-six weeks, cash--fifty per cent of wage from the fourth day of illness, and funeral benefits. In 1930 dependents were added.

f. Conclusion

Table 9 on Page 78 shows the development of Sickness Insurance in Germany which was progressing quite well until the Hitler regime took over. A good percentage of the population was eligible, making the coverage worth fifteen points. The financial arrangements were satisfactory and worth twenty. The administration was too bureaucratic,

---

(1) Metropolitan Life Insurance Company, op. cit., Page 24
(2) Ibid, Page 24
(3) Millis, op. cit., Page 57

TABLE 9

Major Developments of Sickness Insurance in Germany
(Population: 62,300,000 Number Insured: 20,000,000)

	Original Act 1883	Principal Changes and Developments	Present Provisions
Scope	Industrial wage earners	Additions as follows: 1885--commerce 1886--agriculture in part 1892--home workers and various public servants 1911--domestic servants and agriculture 1892--income limit of 2000 marks ($476) introduced	All wage earners including apprentices. Income units of 3600 RM ($858) per annum for manual workers in responsible positions and 2700 RM ($643) per annum for non-manual workers
Cash Sickness Benefits	Not less than 50% of the basic wage payable for the duration of sickness up to the end of the 13th week. Maximum basic daily wage, 3 marks (71 cents)	1903-Maximum benefits made payable for 26 weeks. Increase in proportion of women insured caused by the war led to increases in payments for sick benefit.	Not less than 50% of the basic wage payable for the duration of the sickness from the 4th day up to the eend of 26 weeks. Maximum basic daily wage 10 RM ($2.38)
Medical Benefit	Treatment and appliances for the duration of cash benefit	1903--Allowed for 26 weeks	Treatment and appliances for not more than 26 weeks or as long as cash benefits continue if these have been prolonged. Hospital treatment with a reduction in the cash payments.
Maternity Benefit	For 3 Weeks	Extended to 4 weeks in 1892 and 6 weeks in 1903	Sickness payments for approximately 12 weeks, a lump sum of 10 RM ($2.38) Attendance and appliances. No payments unless the mother has been insured 10 months in the proceeding 2 years and 6 months in the proceeding year.
Other Benefits	Funeral benefit		Funeral benefit 20-40 times the basic daily wage. Additional benefits
Sources of Funds	Workers pay 2/3 and employers 1/3 of total contribution	1903--Total contributions limited to 4% of earnings	Workers pay 2/3 and employer 1/3 of total contribution. State pays 1/2 of the maternity benefits for insured wives of insured persons. Total contribution limited to 7.5% of earnings.
Administration	The handling of benefits and contributions are in the hands of: 1. Local and rural funds set up by the government for territorial divisions. 2. Workers funds set up for industrial establishments. 3. Previously existing guild, mining, and mutual benefit funds approved by the government. Funds may form federations for greater efficiency in working.	State Insurance Act of 1911 codified the various insurance laws into a single whole, while leaving each branch of insurance independent, and set up grades of supervisory bodies as described in the next column. Also introduced measures for concentration leading to a reduction in the number of funds from about 20,000 to about 8,000. Acts of 1924, 1925, 1926 made further improvements leading to the federal insurance code as it now stands.	The various funds and federation of funds are directly supervised by local insurance offices set up as rule in connection with every subordinate administrative authority. These in turn are grouped under regional insurance offices set up for the districts of each administrative authority. Lastly, the federal insurance office in Berlin exercises extreme administrative and judicial power.

Source - Metropolitan Life Insurance Company, "Health Insurance", Monograph 3, June, 1931, Page 8

particularly as the individual had no choice of society and so worth only ten points. The service was complete (twenty points) and of good quality (twenty points). Thus the plan should receive a weight of eighty-five points.

A comparison of the Denmark and Germany plans is interesting because whereas in the former, the member may choose his self-governing society of insurance, in the latter it is determined according to his place of work. In each the insured contributes about two thirds, the other one third being contributed by the state in the former plan and by the employer in the latter. The benefits are quite similar.

The following conclusions (1) were made by I. G. Gibbon in a study which he made of the above plans and are applicable to the whole problem of medical insurance and hence worthy of brief mention:

1. "Medical service should be provided in kind in order that the society can better control the doctors and thereby ensure good medical treatment and abuses can better be detected."

2. "Direct dealing by the societies with the doctors in medical matters is advantageous."

3. "In sickness insurance, free choice of the doctor should be considered."

4. "In insurance against disablement the insurance author-

---

(1) Gibbon, I. G., "Medical Benefit in Germany and Denmark", E. P. Dutton and Company, 1913

ity should employ special doctors to examine the claimants."

5. "Payments for medical insurance should be in the form of capitation fees to medical societies so that the insurance organization need not decide payments to doctors."

6. "Individual doctors should be remunerated according to services rendered or they will not do their best."

7. "If the society contracts with a corporation of doctors the above can be accomplished."

8. "Abuse will be reduced if the individual pays part of the cost out of his private resources."

9. "Systematic provision should be made for educating the insured public as to medical treatment and health."

10. "A distinction should be made between those with large and small incomes."

11. "Strict control should be exercised over medical practitioners through the organization of doctors. The society should control administration and expenses."

12. "Provision should be made for conciliation and arbitration."

13. "Provision for medical and surgical benefits should be included."

14. "Societies should be allowed discretion as to the manner in which benefits shall be provided."

15. "Control should be exercised over abuse of prescriptions by pharmacists."

16. "Provision of institutional benefits is essential and

requires outside help."

17. "Medical practitioners should have no pecuniary inducement to send cases unnecessarily to hospitals."

18. "Home nursing should be provided as should convalescent homes."

19. "There should be close cooperation between the insurance and public health authorities."

4. Great Britain

The medical insurance plan in Great Britain is an outstanding example of a fairly good foreign compulsory insurance plan and is interesting particularly when contrasted with that of Germany described above.

a. Origin, Development, Eligibility, and Coverage

In 1941, four and one half million wage earners in Great Britain were insured against loss of wages through friendly societies, trade unions, sick clubs, and employer's funds and provided with some means of medical care. This number was increased to thirteen million, seven hundred and nine thousand, and forty-seven in 1912, (1) and to seventeen million in 1932 (2) by the introduction of compulsory national insurance with the result that by 1932, one third of the population was insured against sickness, all persons between sixteen and sixty-five engaged in manual labor and all non-manual laborers with wages under two hundred and fifty pounds

---

(1) Millis, op. cit., Page 74
(2) Metropolitan Life Insurance Company, op. cit., Page 11

pounds (1) being required to become insured. However, persons in the crown's employ and those with unearned incomes of more than one hundred and twenty-seven pounds a year are exempt. (2) The employer is under a legal obligation to see that his employees are insured.

b. Administration

The societies which provided benefits before compulsory insurance was introduced may still administer the plans if organized on a non-profit basis. Physicians and subscribers are both represented. However, each society has a right to exclude persons from membership except on grounds of age. There is an insurance committee composed of a lawyer and two doctors which handles complaints and a National Health Insurance Fund which supervises the plan and the contingencies funds. Government actuaries examine the societies' assets periodically to ascertain what funds are distributable as additional benefits. (3)

c. Financial Arrangements

The plan is financed by contributions from the employer, the insured, and the exchequer. At the end of one half year, the society makes returns of collections to the government and is charged with the cost of medical care received, the balance being available to the society for additional

---

(1) Millis, op. cit., Page 74
(2) Metropolitan Life Insurance Company, op. cit., Page 11
(3) Ibid, Page 11

benefits. The government adds one seventh to the contribution of men and one fifth to the contribution of women, and bears the cost of central administration.(1)

d. Scope of Service

The British plan does not provide burial benefits as does the German plan but does provide sickness, disablement, maternity, and medical benefits, the latter being arranged for and supervised by the local committees. Sickness benefit is paid for any illness except that due to industrial injury and payments begin the fourth day, and last for twenty-six weeks.(2) The amount of sickness benefits for men is three dollars and sixty-five cents a week and for women, two dollars and ninety-two cents.(3) Benefits are payable upon notice to the carrier and presentation of a physician's certificate of incapacity to work. The benefit is continued at half the full rate after the twenty-six week period. There are also maternity benefits of nineteen dollars and forty-seven cents for insured women.(4) The right to medical care is not extended to dependents but the insurance committee in each area does, however, arrange for the necessary medicine and drug service.

e. Quality of Care

Quality of care is good because the doctors are free from control by the insurance carriers and are represented in

---

(1) Metropolitan Life Insurance Company, op. cit., Page 11
(2) Millis, op. cit., Page 83
(3) Metropolitan Life Insurance Company, op. cit., Page 11
(4) Ibid, Page 11

the administration as are the public. A physician has a right to be placed on a panel unless removed for cause. The insured may choose any panel doctor in the area if the doctor accepts him and may change doctors. The doctor is remunerated on a per capita basis and may have a maximum of twenty-five hundred insured workers. (1) He may engage in private practice also. The panel system tends to limit the care received and reduce the quality.

f. Conclusions

The British plan may be criticized because the benefits are low compared to the salary earned by the worker in health and because there is considerable abuse of the plan as evidenced by the apparent increases of sickness during strikes. (2) The doctors are too easy with fakers because they fear the loss of their patients if they should fail to certify their illness. Therefore, a plan where the doctors are hired by the insurers might be better. Another criticism of the Great Britain plan is that only cash is provided for maternity cases whereas in most countries, service is provided. Care by panel doctors has proved better than that by contract doctors to sick clubs but by no means satisfactory although the doctors are fairly well satisfied with the plan.

(1) Metropolitan Life Insurance Company, op. cit., Page 11
(2) Ibid, Page 14

Tables 10 and 11 on Pages 86 and 87 provide a good summary of the British plan and its financial features respectively. David Lloyd George in speaking of the British plan said,

> "In the quarter of a century which has elapsed since it became law this once abused scheme has become one of the most popular elements in our administrative system. The nation would as soon think of abandoning it as it would of abolishing the post office. The medical profession which at the outset viewed it with unconcealed distaste now finds it a highly satisfactory source of income considerably in excess of that which they formerly secured from the section of the public which it covers. The insured classes enjoy by means of it a degree of medical attention previously unknown as well as a measure of financial security in sickness to which they were once strangers. Its reputation in America suffers both from lack of information and misinformation. Defects or occasional rare abuses which come to light are exaggerated and serve to obscure for the distant looker-on its immense positive worth and the high esteem it has won."(1)

Thus, although the British plan is a good attempt it might well be extended to cover dependents and those excluded under the present low financial income limits necessary for eligibility, and to offer specialist care, lab facilities, dental benefits, and periodic examinations. Sir William Beveridge has recently introduced a more inclusive plan(2) and says, "So far as sickness is concerned, prevention and cure of this by the establishment of a comprehensive health service for all citizens is a cardinal feature of this

---

(1) Orr, Douglas W. and Jean Walker, "Health Insurance with Medical Care --The British Experience" The Macmillan Company, New York, 1938, Page 5
(2) See Page 88

TABLE 10

Major Developments of National Health Insurance in Great Britain

Population: 45,700,000; Number Insured: 16,400,000

	Original Act 1911	Principal Changes and Developments	Present Provisions
Scope	All manual workers and non-manual workers earning not more than 160 pounds ($779) a year between the age of 16 and 17	1920 Act--income limit raised to 250 pounds ($1,217) a year. 1925 (contributory pensions) Act. Upper age limit changed to 65 i.e. age at which contributory old age pensions fall due.	All manual workers and non-manual workers earning not more than 250 pounds ($1,217) a year between the ages of 16 and 65
Cash Sickness Benefit	10 shillings ($2.43) a week for men and 7 shillings ($1.82) a week for women payable for the duration of 26 weeks. No payments during the first 6 months of membership and a reduced amount only during the next 1½ years.	1920 Act-- Weekly payments increased 50% in case of men and 60% in case of women.	15 shillings ($3.65) a week for men and 12.5 ($2.92) a week for women. No change on the conditions of payment.
Cash Disablement Benefit	5 shillings ($1.22) a week for both men and women payable after 26 weeks of sickness benefit. No payment during the first two years of membership.	1920 Act--Weekly payments increased 50%	7 shillings 6 pence ($1.82) for both men and women. No change in the conditions of payment.
Medical Benefit	All proper and necessary (excluding specialist treatment) Approximate annual charge on the funds 6s 6d ($1.58) per person.	1920 (economy) Act. Annual charge on fund increased by 3s (73¢) per insured person.	As in original act with approximate annual expenditure allowed for each insured person raised to 9s 6d ($2.31)
Maternity Benefit	Lump sum of 60 shillings ($14.60) for each insured wife or 30 shillings ($7.30) if the husband alone is insured or woman is unmarried. No payment during first 42 weeks of membership.	1920 Act--Cash payments increased by 33 1/3%	Lump sum of 80 shillings ($19.47) for each insured wife; or 40 shillings ($9.73) if the husband alone is insured or woman is unmarried. No change in the conditions of payment.
Other Benefits	Additional benefits, such as: Increases in above payments. Benefits to members of the family. Sanatorium treatment for tubercular cases. Special grants in cases of distress may be made by societies whose quinquennial valuations show an available surplus.	Sanatorium benefit transferred to a new Public Health Service	Some original benefits allowed as provided for in the original act except sanatorium treatment
Sources of Funds a. Employer b. Insured Person c. State	Weekly contributions man a. 3d(6c) b. 4d(8c) woman a. 3d(6c) b. 3d(6c) proportion of cost of benefits and control administration paid by the state. c. 2/9m 1/4w Deductions are made from contributions equal in amount to the state share in the cost of benefits and administration in order to redeem reserve value credited to original members over 16, the contributions having been calculated on the basis of a plan supported only by contributions of members entering at that age.	1918 Act--increases made in the proportions of the contribution diverted to redeem initial reserves and deductions made from these increased diversions in order to create special funds (contingencies fund and central fund) 1920 Act--contributions increased to man a. 5d (10c) b. 5d (10c) woman a. 5d (10c) b. 4d (8c) 1925 Act--Savings effected by lowerings of upper age limit led in the following year to reductions of contributions and of the state's share in actual disbursements as shown in the next column.	As determined by the 1926 viz weekly contributions: man a. 4½d(9c) b. 4½d(9c) woman a. 4½d(9c) b. 4 d(8c) Proportion of cost of benefits and central administration paid by the state: c. 1/7m 1/5w Deductions are made from contributions, equal in amount to the state's share in cost of benefits and administration in order to redeem "reserve values" credited to original members over 16, the contributions having been calculated on the basis of a plan supported only by contributions of members entering at that age.
Administration	Central Ministry of Health and Insurance Fund. Local "approved societies" administer cash benefits, "insurance committees" administer medical benefits	1918 Act--Creation of special funds viz 1. Contingencies fund for each society 2. Central fund--a national reserve 3. Women's equalization fund (exchequer grant) 1924 Act--Consolidated existing legislation and set up a royal commission to review the whole system. 1925 Act--Effected a large reduction in the number of approved societies. 1926 Act--Adopted a new basis of valuation recommended by the royal commission of 1924 thus making it possible to reduce contributions as above.	

Source - Metropolitan Life Insurance Company, "Health Insurance", Monograph 3, June, 1931, Page 12

TABLE 11

Financial Features of British Health Insurance

(In Dollars)

Year	Total Income	Total Expenditures	Percent Total Expenditure is of Total Income
1916	$117,500,000	$ 75,600,000	64%
1917	$124,400,000	$ 73,300,000	59%
1918	$136,100,000	$ 82,700,000	61%
1919	$143,900,000	$ 94,700,000	66%
1920	$176,000,000	$127,400,000	72%
1921	$197,800,000	$145,300,000	73%
1922	$182,800,000	$144,600,000	79%
1923	$184,500,000	$142,900,000	77%
1924	$193,400,000	$150,500,000	78%
1925	$200,700,000	$157,800,000	78%
1926	$182,100,000	$180,300,000	99%
1927	$192,400,000	$199,000,000	103%
1928	$188,500,000	$182,900,000	97%
1929	$191,300,000	$194,100,000	101%

Source - Metropolitan Life Insurance Company, "Health Insurance, A Summary of Some Existing Plans Providing Protection in Event of Sickness or Invalidity", Monograph 3, June, 1932, Page 17

plan."(1) He continues, "The proposals rest on the principle that it is the duty of the citizen to be well and of the state to insure, in the common interest that he has the means of being well."(2) With these principles in mind, Beveridge proposes extending the coverage to persons in the government service and providing whatever medical treatment is required in whatever form it is required: home or hospital; general, specialist, or consultant; drugs, dental, ophtalmic, surgical supplies; nursing; rehabilitation, etc.(3) The plan also contemplates, "The separation of medical treatment from the administration of cash benefits and the setting up of a comprehensive medical service for every citizen covering all treatment and every form of disability under the supervision of the health department."(4) Under the Beveridge Plan, the cost would be shared by the employer, the insured, and the state, and there would be no charge at the time of treatment. The expense would be about one third the national income.(5) Under this plan, preventive medicine could be practiced and research undertaken under a unified administration. As has been shown, this laudable objective has not yet been reached.

In conclusion, the British plan is a good attempt in the right direction but does not go far enough. Tables

(1) Beveridge, William, "Health and Security in Britain", Survey Graphic, Volume 32, Number 7, Page 285
(2) Ibid, Page 286
(3) Ibid, Page 286
(4) Commonwealth of Massachusetts, State Advisory Council of the Division of Employment Security, op. cit., Page 17
(5) Beveridge, op. cit., Page 285

10 and 11 on Pages 86 and 87 indicate the main provisions of the plan and the financial features respectively. From the latter it can be seen that the expenses have steadily mounted so that they now exceed the income.

In rating the British plan as to eligibility and coverage the fact that dependents are not included must be considered as reducing the worth of this feature to fifteen points. The administration is excellent--both physicians and the public being represented--and is worth twenty points. Financial burdens are shared by state, employer, and employee. (Twenty points) The scope of service is worth only fifteen points because specialist care, laboratory service, dental benefits, and periodic examinations are not included. The quality of service rates only fifteen points because an ineffective system is used in which often the patient does not receive adequate attention. The total weight for the plan is eighty-five points which compares creditably with that of Germany although the various separate items differ considerably. If these were assigned different values by an expert, the totals might also change.

5. France

a. Origin and Development

Before closing the subject of government insurance and in order to get a more complete picture thereof, a word or two should be said about the French, Russian, and New Zealand systems. Voluntary insurance through mutual organi-

zations as that of the miners prevailed in France until 1928 when a national system which covered nine million, eight hundred thousand workers in industry, commerce, and urban occupations and one million, one hundred thousand agricultural workers was adopted.(1)

b. Eligibility and Coverage

The plan covers all wage earners between the ages of thirteen and sixty who earn less than twenty-five thousand francs a year including home workers, taxi drivers, travelling salesmen, baggage porters, theatre attendants, hotel and cafe employees, miners, seamen, public utilities employees, civil servants, etc.

c. Administration

The carriers which are primary funds consisting of mutual benefit societies, trade unions, voluntary associations, and territorial funds created by the government(2) control the administration. However, the doctors are in charge of all medical matters.

d. Financial Arrangements

The insured and the employer contribute equally towards the financing of this French plan and the government adds a subsidy. Until 1935 the insured were divided into five classes on the basis of wage rates and there was a fixed charge for each class as in Germany. In 1935, this was

(1) Millis, op. cit., Page 104
(2) Ibid, Page 106

abolished in favor of contributions calculated on actual salaries.

e. Scope of Service

Cash benefits of fifty per cent of the wages are now given after the sixth day of disability and are continued for twenty-six weeks.(1) If premiums have been paid for two years the ensured is entitled to medical attention for five years and then a permanent pension depending on his wage, age, and number of years insured. The wife and children under sixteen have a right to medical care of a general practitioner, specialist, surgeon, dentist, and eighty per cent of the cost of hospital care for twenty-six weeks as in Germany, not England.

f. Quality of Care

The quality of care is good because the patient can select any doctor. As can be seen, the French system is designed to meet the demands of the doctor and to conserve freedom of medical practice. The physician certifies the incapacity of his patient but does not have to report the nature of the disease.(2) Thus no data for prevention is accumulated. This plan entrenched private practice more than in any other large compulsory insurance country and naturally necessitates investigation and creates more confusion than the German or British systems. A rather unique feature of the French plan is that the insured may pay the physician

(1) Millis, op. cit., Page 102

(2) Commonwealth of Massachusetts, State Advisory Council, Division of Employment Security, op. cit., Page 13

and are later reimbursed by the insurance society.(1)

g. Conclusions

The eligibility and coverage feature of this plan is restricted to those earning less than twenty-five thousand francs and hence should be alloted fifteen points. The administration, which is controlled by the society and the doctors, is worth only fifteen points because of the resulting confusion. The financial arrangements are adequate. (Twenty points) The scope of service is not complete and so is worth fifteen points. The quality of service deserves twenty points making the total for the plan, eighty-five.

6. Russia

It is interesting to note that in Russia, Health Insurance is divorced from private enterprise and charity and all medical institutions and personnel are provided and maintained by the state, all services being free. The plan is administered centrally by the Commisariat of Health and locally by the Commisariats of Health in the Federated Republics. Each local soviet has a health department and each group of workers has a health committee. The district "prophylactorium" is the medical center.(2) Except for the administration which is completely controlled by the government and hence worth only ten points, the other features are each

---

(1) Commonwealth of Massachusetts, State Advisory Council, Division of Employment Security, op. cit., Page 13

(2) Johnson, Julia E., "Socialization of Medicine", Supplement to the Reference Shelf, Volume 10, Number 5, December, 1935, Page 9

worth twenty points, making a total of ninety for the plan.

7. New Zealand

a. Eligibility, Coverage, and Administration

Mention of one more foreign plan, that in New Zealand, will round out the picture of government medical insurance. Under the New Zealand Social Security Act of 1938, health benefits are to be administered by the Ministry of Health and to be available to all residents.(1)

b. Financial Arrangements and Scope and Quality of Service

The funds are to be raised through payments by the employed and taxation. Services include that of a general practitioner of the patient's choice who is to be remunerated from the Social Security Fund at a rate of one dollar and fifty cents per visit plus mileage or is to be remunerated on a panel and capitation basis. Specialists' services are not covered but free choice of hospitals is provided as are maternity benefits which include physician's service, home nursing, hospitalization, and nursing. The Council of the New Zealand Branch of the British Medical Association decided to charge the patient the ordinary fee and furnish him with a receipt for a refund, and a controversy resulted. Finally on November 1, 1941 a compromise was arrived at and the fee basis was adopted.(2)

c. Conclusions

As can be seen, this plan differs from other plans

(1) Medical Care, "New Zealand Medicine", Volume 2, Number 1, January, 1942, Page 59
(2) Ibid, Page 59

in several respects. Everyone is eligible regardless of employment. (Twenty points) The administration is controlled by the Ministry of Health and hence is worth only fifteen points. Financially, this plan is weak because the patient must still bear a considerable burden. (Fifteen points) Benefits are not all inclusive. (Fifteen points) The service is excellent because the physician is not inhibited. (Twenty points) Thus the plan is worth eighty-five points.

I. Conclusions

Thus it can be seen that there are many different types of government insurance plans, local, state, and national; voluntary and compulsory. It is not the purpose of this thesis to suggest that one of these plans is the best plan, although it appears that the proposed New York City Plan (1) meets most of the requirements. The aim of this thesis is to present the plans and later to compare them so that those interested and qualified can, by changing the weights, determine which is the best for a particular purpose. The suggested Wagner-Murray-Dingell Bill (2) for national compulsory health insurance has proved to be one of the most controversial subjects in the field. As explained above, there are points on both sides. Many people fail to realize that the government is already playing a large part in the field of medicine. There are many federal, state, county and city government tax-supported hospitals; hospital care for those

(1) See Page 44
(2) See Page 61

mentally sick is provided by the government as is care of veterans; the United States Public Health Service and the state departments of health are very active as are such federal agencies as the Children's Bureau. Thus a new plan would supplement, not replace, the existing plans. It is becoming apparent that if better medical care at costs that can be borne is going to be provided, doctors and hospitals cannot maintain isolation any more than can the United States secure peace by isolation. Of course, compulsory government insurance is but one of many solutions to the problem of medical insurance and it would perhaps be wise not to attempt compulsory government insurance in the United States until it has definitely been proved that voluntary methods if extended are inadequate.

With regard to foreign plans, it is worth noting that the need for security benefits to workers in Europe is greater than in the United States where wages are higher.

In most of these countries eligibility and coverage are confined to employed persons and are by no means all inclusive.

It is interesting to note that whereas in England(1) as shown above, the cash benefit is a fixed sum, in Germany(2) and most of the other countries it is a

---

(1) See Page 81
(2) See Page 75

it is a certain percentage of the wages. This same difference applies to the financial arrangements, the burden of which is usually shared by the employer, employee, and state. The difference in the scope of service of the British plas as compared with that of Germany is rather striking also. In the latter much more complete service is offered than in the former.

Industries are desirous of preventing the government from taking control and hence are establishing plans of their own, as shown in Chapters VI, VII, and VIII.

Private association plans as the Blue Cross, Medical Society plans, Group Clinic, and Cooperative plans are doing their part also. As these types of plans are all sponsored by voluntary non-profit organizations divorced from industrial control, unlike the plans of the government, labor unions, insurance companies, and industries, they will be grouped together as a unit and discussed in the next chapter.

CHAPTER III

VOLUNTARY, PRIVATE ASSOCIATION, [illegible] PRACTICE, MEDICAL SOCIETY, GROUP CLINIC, AND COOPERATIVE PLANS

A. Voluntary Non-Profit Private Association Plans

1. Opposition to Compulsory Plans

The problem of voluntary plans was touched upon briefly in the discussion of government plans above (1) at which time were pointed out some of the arguments regarding each type of insurance. The American Medical Association opposes governmental control of medical practice because it allegedly denies the physician basic freedom of practice. At first there was considerable opposition by the medical profession to voluntary systems but recently the American Medical Association has supported voluntary plans as the lesser of two evils. Governor Saltonstall of Massachusetts said,

> "Throughout its entire history the fundamental principle of our democracy as of every other democracy has remained the same; The performance by government of only such services for the benefit of the individual citizen as he believes can best be performed by all citizens acting for the common good--The average citizen wants to discard government by edict, collectivism, and experiments made simply for the sake of a change. He rightly fears the weakening of individual enterprise, initiative, and resourcefulness by an overgrown central government. The great personal virtues bestowed by Washington, Jefferson, and Lincoln must be revived. The country was built from the bottom up and not from the top down and we must not reverse the direction."(2)

(1) See Page 43

(2) Mannix, John R., "Voluntary Non-Profit Prepayment for Health Care", Journal of the American Medical Association, Volume 124, Number 9, February 26, 1944, Page 572

This is the attitude of most of the medical profession also. It is feared that medical progress would be halted by upheaval from compulsion and that voluntary insurance can accomplish the desired results in time.

2. Accomplishments

The following can be considered accomplishments of the voluntary system of medical practice:

"1. Education of one hundred and forty thousand physicians, sixty-six per cent in private schools.
2. Education of seventy thousand dentists, seventy-seven per cent in private schools.
3. Education of four hundred thousand nurses, mostly in private schools.
4. Providing the armed forces with forty thousand physicians, fifteen thousand dentists, and fifty thousand nurses.
5. Four thousand and twenty-one hospitals, sixty-six under private supervision.
6. Three hundred and sixteen thousand hospital beds erected through voluntary giving at a cost of one million six hundred thousand dollars.
7. Care of eight thousand five hundred hospital patients in 1943, sixty-eight per cent of all patients admitted to hospitals.
8. Birth care of one million, four hundred thousand infants, eighty-two per cent of children born in hospitals.
9. Extension of the span of life from thirty-four to sixty-four years between 1879 and 1943.
10. Non-profit hospital plans in thirty-six states and medical service plans in sixteen."(1)

All these are important accomplishments but should not lead one to the conclusion that voluntary plans can alone solve the problem, because help of the government is needed in public health, control of communicable diseases, care of tuberculosis, care of nervous and mental diseases, care of the

(1) Mannix, op. cit., Page 573

chronically ill, care of war veterans, care of the indigent if they cannot be cared for by private physicians, etc. Perhaps the solution would be for the government to supplement and not to supplant the voluntary system. The following are some of the things voluntary systems could accomplish through private leadership: plans in every state, mergers of hospital plans, uniform contracts providing comprehensive service, health care plans available to rural population, health care plans available to self-employed and employees of small businesses, extended protection to those unable to pre-pay, prepayment of dental and nursing service, public education, etc. Thus it can be seen that voluntary insurance has not yet accomplished all it possibly can. Maybe more time should be allowed before the introduction of a compulsory system.

There are various types of voluntary plans. The object of all as of compulsory plans is to make the costs due to sickness predictable and bearable by making small payments into a common fund. Some voluntary plans provide services in return for cash, whereas others pay cash to the insured to compensate for the loss of income due to illness and to help pay the medical costs. The sponsoring of these plans varies greatly. In this chapter the main concern is with non profit prepayment societies as exemplified by the Blue Cross, Medical Society Plans, group clinics, and cooperative plans. One main trouble with such plans is that many people cannot afford or are not willing to purchase the insurance. Many plans have limits of two thousand dollars

annual income which prevents those who can afford the insurance from joining. The actuarial basis for hospitalization plans is the observation that one out of every ten people receive an average of ten days hospitalization a year.(1) Thus out of one thousand people insured, one thousand days of hospitalization can be expected in one year.(2)

3. Voluntary Plans in Massachusetts

Before discussing a specific voluntary non profit private association plan as the Blue Cross, it might be well to note the extent to which voluntary plans contribute to the objective of complete coverage. Those in the state of Massachusetts will serve as a good example. In a survey of eight thousand one hundred and fifty-six Massachusetts employers conducted in January of 1944 by the State Advisory Council of the Division of Employment Security, the following results appeared:

Six hundred thousand workers or sixty-five and nine tenths per cent of the employees received some payment for periods when they were absent from work because of illness.(3)

Group Health Insurance was the sole source of payments in establishments employing twenty-six and five tenths per cent of the estimated covered workers and was one of the sources in an additional twenty-one and two tenths per cent.(4)

---

(1) Faxon, Nathanial W. "Health Insurance Plans", Lecture at Harvard Medical School, February 2, 1945

(2) Ibid

(3) Commonwealth of Massachusetts, op. cit., Page 36

(4) Ibid, Page 37

The employer assumed the entire financial burden of supporting the plans covering thirty-two and five tenths per cent of the workers receiving disability payments and financed part of the plans covering sixty and one tenth per cent of the workers.(1)

Only seven and four tenths per cent of the workers were employed in establishments where the employer contributed nothing.(2)

There are five hundred and seventy-two Fraternal Benefit Societies covering one hundred and fifty-one thousand five hundred and sixty-three additional workers not included above.(3)

The number of inhabitants of Massachusetts insured under group Health and Accident Insurance Plans with private insurance carriers was not readily obtainable but that this number is quite large can be deduced from the figures shown in Table 12 on Page 102.

That the coverage in Massachusetts is accelerating may be shown from the fact that premiums have increased one hundred and forty-five per cent in the past ten years and three times as much in the second five years as in the first.(4)

(1) Commonwealth of Massachusetts, op. cit., Page 37
(2) Ibid, Page 37
(3) Ibid, Page 38
(4) Ibid, Page 39

TABLE 12

Group Insurance in Massachusetts + the Other States

Type of Insurance	Number of Insured
Group Health and Accident	6,500,000
Group Hospital Expense	6,100,000
Group Surgical Operation	3,750,000

Source - Commonwealth of Massachusetts, Division of Employment Security, State Advisory Council; Report on Sickness Benefits, Wright and Potter Printing Company, Boston, Mass., November 1, 1944, Page 39

In Massachusetts one million three hundred and fifty thousand participants are covered under Blue Cross plans.(1)

Besides these, there are in Massachusetts union plans, company or employee medical service plans, medical society plans, cooperative group and consumer sponsored plans, the Farm Security Administration Plan, and private group practice clinics.

The above discussion of voluntary plans in Massachusetts is sufficient to indicate that voluntary plans are contributing their part and should be given a fair trial. The Massachusetts Blue Cross Plan is a good example of a voluntary non profit private association plan and is worthy of further discussion and consideration.

4. The Massachusetts Blue Cross

a. Origin and Development

---

(1) Blue Cross Office

Before considering the details of the Massachusetts Blue Cross Hospitalization Plan, it would be well to get an overall picture of the work and national accomplishments of the Blue Cross organization which started in 1929 when a group of fifteen hundred school teachers asked Baylor University Hospital how they could protect themselves against hospital bills. Baylor University agreed to look after the teachers for three dollars a semester from each teacher.(1) This plan had the proper arbitrary group basis so it worked. Soon the employees of a Dallas bank joined as did other employee groups until Baylor had twenty thousand pre-paying potantial patients.(2) Other Dallas hospitals started similar schemes and soon other cities followed suit. Inter-hospital competition began to deprive the patient of choice of hospital until Thomas Van Dyck signed up all hospitals in Essex County, New Jersey, in advance into one central organization. He pooled all subscribers and guaranteed service in any member hospital. The Blue Cross Emblem was originated by E. A. Van Steenwyk of St. Paul, Minnesota, in 1933.(3) By early 1945 there were more than seventeen million subscribers to Blue Cross in forty-seven states(4) and seventy-seven non profit Blue Cross Groups(5) and the number is still growing.

---

(1) Furnas, J. C., "This Cross in Blue", Saturday Evening Post, Volume 216, Number 15, October 2, 1943, Page 19

(2) Ibid, Page 19

(3) Faxon, Nathanial W., "Health Insurance Plans", Lecture at Harvard Medical School, February 2, 1945

(4) Ibid

(5) Business Week, "Blue Cross Gains", March 18, 1944, Page 44

In 1937 the Julius Rosenwald fund subsidized the Blue Cross on a large scale. Although the organization is not national, the Blue Cross is the seal of approval conferred on local hospital insurance groups which meet the standards of the American Hospital Association, and members in one city can get hospitalization in another, benefits usually including the entire cost of a hospitalized illness except the doctor's personal bill. Indiana is the only state without a Blue Cross plan and there is legislation against establishing the plan there.(1) Most of the hospital plans have built up surpluses for emergencies and have been generally successful. The biggest potential threat to the Blue Cross is the Wagner Bill which would make health insurance compulsory. However, despite the many threats to their existence, non profit plans have already enrolled more than ten per cent of the population(2) and have overcome the competition of accident and health insurance companies.(3) During the depression the hospitals were helped by this plan as well as the patients.

No two Blue Cross schemes are exactly alike but they are all similar. It is interesting to note that some of the member hospitals guarantee to take care of the patient even if the Blue Cross miscalculates and goes broke.(4)

(1) Business Week, op. cit., Page 44
(2) Ibid, Page 44
(3) Furnas, op. cit., Page 19
(4) Ibid, Page 18

The extent of the coverage may be exemplified by the experience of one Blue Cross member who received in New York a check for sixty-seven dollars for a hospital bill he had paid to the Shanghai County Hospital in China.(1) This is just one from among many examples of how far this plan goes, it being estimated that the Associated Hospital Service of New York pays a hospital bill every four minutes.(2) Some of the Blue Cross Hospital Plans are joined with other voluntary Health Insurance plans providing physicians' service. The Massachusetts ward and semi-private Blue Cross plans which are under the auspices of Massachusetts Hospital Service Inc. constitute a good example of Blue Cross plans.

b. Eligibility and Coverage

There are at present one million three hundred and fifty thousand subscribers to the Massachusetts Blue Cross Plan.(3) Eligibility to the ward plan is very restrictive being granted if the subscriber's income falls into one of the classes listed in Table 13 on Page 106.

It should be noted that the semi-private plan may be joined regardless of income and that changes in family status or employment are easily adjustable.(4) Individuals must belong to a group to become a member.

c. Administration

There are sixteen men on the board and the majority

---

(1) Time, "Blue Cross", Volume 43, Number 4, January 24, 1944, Page 47
(2) Ibid, Page 47
(3) Faxon, op. cit.,
(4) Ibid

TABLE 13

Massachusetts Blue Cross Income Restrictions--Ward Plan

Coverage--Eligible Persons	Amount of Annual Income
Single subscriber-no dependents	$1000.00 or less
Subscriber and one dependent	$1250.00 or less
Subscriber and two dependents	$1500.00 or less
Subscriber and three dependents	$1750.00 or less
Subscriber and four or more dependents	$2000.00 or less

Source - Massachuestts Hospital Service Inc., "Blue Cross".

of these are on hospital staffs and are therefore supposedly interested in the success of the plan. The state commissioner of insurance has final authority in administering the plan.(1)

d. Financial Arrangements

The monthly rates for each plan are as shown below in Table 14.

TABLE 14

Massachusetts Blue Cross--Monthly Rates

	Ward Plan	Semi-private Plan
Individual	.60	.85
Husband and wife	1.00	1.65
Husband, wife, and Family	1.25	2.00

Source - Massachusetts Hospital Service, "Blue Cross"

---

(1) Faxon, op. cit.

If semi-private plan members use private rooms a credit will be allowed and if a ward plan member uses semi-private or private accomodations or ward accomodations in other hospitals, the Blue Cross will pay four dollars and fifty cents (1) per day toward the hospital bill.

e. Scope of Service

As the average length of stay is only fourteen to fifteen days, (2) services under both the ward and semi-private plans can be offered for thirty days for each admission plus fifty per cent of the cost of services for an additional ninety days (3) and include the following: room; meals and special dietary service; general nursing service; operating room; anaesthesia when administered by a salaried employee of the hospital; all medications including intravenous solutions; all dressings including bender bandages, casts, crutches, and slings; all drugs--oxygen, oxygen tent or face mask and helium; all sera; all laboratory examinations done in the hospitals including blood chemistry and culture, electrocardiograms, and electroencephalograms done in the hospital. (4) For maternity cases there is a nine month waiting period after which the Blue Cross will pay half the hospital charges. (5) One half benefits are offered for tonsil and adenoids removal of dependent children after twelve months of membership. (6)

---

(1) Massachusetts Hospital Service Inc., "Blue Cross".
(2) Faxon, op. cit.
(3) Massachusetts Hospital Service Inc., op. cit.
(4) Ibid
(5) Ibid
(6) Ibid

For all other conditions, all Blue Cross benefits are available on and after the day membership starts.(1) The plan does not provide for hospitalization for mental, quarantinable, tubercular, or workmen's compensation cases, (except the difference in the latter payment and Blue Cross benefits), or out patient service (except for emergency treatment after an accident).(2)

f. Conclusions

As can be seen, the Massachusetts Blue Cross Plan provides fairly complete hospital care. It is interesting to note that it differs from that in most states in that it pays the hospitals the same amount as do individuals whereas in most states the Blue Cross pays a set sum which may cause the hospital to gain or lose on the transaction more than they would on an individual patient.(3)

As eligibility to the ward plan is subject to income limitations, it is worth only fifteen points. The administration, which is fairly good but does not include representatives of the subscribers, likewise is worth fifteen points. The financing, in which the subscriber is not helped, also deserves fifteen points. Because the care of a physician outside of the hospital is not provided, the scope of service is worth only fifteen points. The quality of service

---

(1) Massachusetts Hospital Service Inc., op. cit.
(2) Ibid
(3) Faxon, op. cit.

when provided is excellent and deserves twenty points, making a total of eighty for the plan. This total is on the basis of complete service. However, it must be kept in mind that as the plan is accomplishing what it has set out to accomplish it is an excellent plan.

C. Medical Society Plans

1. Origin and Development of Medical Society Plans

Medical Society Plans being another type of non-compulsory plan offered to industrial workers and others, it would be wise to discuss them in this chapter along with Blue Cross, Cooperative, and Group Clinic Plans which are also non profit organizations divorced from industrial control.

The United States and Canada are the only countries in which the medical profession has started Health Insurance plans under its own auspices.(1) No treatment of Medical Insurance would be complete without a consideration of the achievements of Medical Societies in this line. Voluntary health insurance began in mining and lumbering camps, where because of isolation it was necessary to bring medical care. By 1930 there were a few organized groups of private physicians undertaking to supply medical care on a prepayment basis to organized subscribers. In February, 1933, the American Hospital Association approved of hospital insurance to solve the distribution of the cost of hospital care and

---

(1) Davis, Michael M., "Health Insurance Plans Under Medical Societies", Medical Care, Volume 3, Number 3, August, 1943, Page 217

in 1942 there were seventy such plans.(1) In 1932 the American Medical Association approved cash indemnities against costs of catastrophic illnesses if administered under commercial auspices, and medical bureaus were organized by physicians in Washington and Oregon to furnish service by contract with employers and employees. Gradually some of the state societies began to sponsor plans; those in Michigan, California, Massachusetts, and New Jersey being particularly good examples.

2. Michigan

a. Origin, Development, Eligibility and Coverage, and Administration of the Medical and Surgical Plans

In 1934 the Michigan State Medical Society organized the Mutual Health Service and in 1939 the Michigan Hospital Service Plan. It sought an enabling act in order to keep its plans under its own control and has now achieved a size of six hundred thousand subscribers.(2) No individual subscribers may enroll in the Mutual Health Service. A group of ten or more, seventy-five per cent of the employees of a company, is required. The plan is administered by a board of directors controlled by physicians and a medical director, and has an arrangement with the Michigan Hospital Service whereby the field agents of one plan obtain subscribers for both. By 1940, three fourths of the practicing physicians in the state had agreed to supply services and offered two plans, one a

(1) Davis, op. cit., Page 218
(2) Davis, Michael M., "Health Insurance Plans Under Medical Societies", Medical Care, Volume 3, Number 4, Page 17

comprehensive one giving complete medical service and the other a surgical plan.

In the fall of 1940, there were seventy thousand members in the Society's plans but only six thousand of these subscribed to the complete medical service. In September of 1941, the surgical plan members rose to one hundred and ninety thousand and in 1942 to four hundred and eighty thousand.(1) It soon became apparent, perhaps because the cost was too high, that the complete coverage plan would not work and so it was discontinued. Under this medical plan subscription rates were two dollars per person per month and four dollars and fifty cents per family per month and physicians services up to three hundred and twenty-five dollars a year for an individual and eight hundred and seventy-five dollars for a family were offered.(2)

b. Financial Arrangements of the Surgical Plan

Under the surgical plan, the schedule of payments contained in Table 15 below apply.

TABLE 15

Schedule of Payments--Michigan Hospital Plan

Patients	Amount Per Month
Subscriber	.60 to .90
Husband and Wife	$1.60
Family	$2.25

Source - American Medical Association, "Medical Service Plans", A Report Prepared by the Bureau of Medical Economics, 1943, Page 37

---

(1) Davis, op. cit., Page 17

(2) Ibid, Page 17

Physicians are paid a fee similar to charges made for persons whose incomes are below two thousand dollars a year. Those who earn more than this may join the plan and be charged additional fees.

c. Scope of Service of the Surgical Plan

The services under this plan include surgical service, operating, and cutting; anaesthesia; diagnosis; X-ray, up to fifteen dollars a year; and obstetrical care after ten months. There are no restrictions in regard to conditions existing prior to enrollment, but the service excludes obstetrics during the first ten months, industrial injuries, services obtainable free from the government, and self-inflicted injuries. One hundred and fifty dollars is the maximum payable for one operation.(1)

d. Conclusions

The coverage of this plan is small compared to the general population but large in relation to that of other Medical Society plans, partly because ninety per cent of the subscribers come from eighteen employed groups, mostly large automobile concerns, and are members of the United Automobile Workers C. I. O. Union which supports the Michigan Medical Service.(2) The coverage is worth fifteen out of twenty points. The subscriber is not represented and hence the administration is worth only fifteen points, as are the financial arrangements which are burdensome on the individual who receives no help.

---

(1) Davis, op. cit., Page 38
(2) Ibid, Page 18

Although the service is limited in scope to surgery and obstetrics and hence worth only ten points, its quality, being provided by approved members of the Medical Society is good and deserves twenty points, making a total for the plan of seventy-five points.

3. Califorma

a. Origin and Development

The California Physicians' Plan which was considerably influenced by the above described Michigan plan, began in 1939 with five principles: "1. Every licensed physician may participate in the plan if he wishes to do so. 2. The physicians will continue in individual competitive practice. 3. Subscribers will have free choice among the doctors who participate. 4. The physicians will be paid as in ordinary practice by fees for services rendered following an agreed upon rate schedule. 5. The policies of the plan are to be controlled by the medical society."(1) These principles are applicable to most medical society plans.

b. Eligibility and Coverage

In the first year of its operation, five thousand doctors and eighteen hundred subscribers participated. This number increased to fifty-two thousand one hundred and nineteen in 1943.(2) There is an income limitation of three thousand dollars but others may join by paying the difference between the fee schedule and the physician's usual charge.(3)

---

(1) Davis, op. cit., Page 19
(2) Ibid, Page 19
(3) Ibid, Page 19

c. Administration

The professional members elect administrative members who in turn elect half as many laymen.(1) The subscribers have no say.

The California Physicians' Plan was established under the non profit corporation laws so as not to be under state supervision. On March 1, 1943 there were eighty-five thousand members as compared to four hundred and forty thousand in the Michigan Plan.(2)

d. Financial Arrangements

The cost to the subscriber is shown in Table 16 below.

TABLE 16

Schedule of Payments--California Physicians Plan

Patients	Cost for 35 Eligibles	Cost for 50 Eligibles
Male Employee	.60 per month	.50 per month
Female Employee	.90 per month	.75 per month
2 Dependents	1.50 per month	1.25 per month
3 or More Dependents	2.25 per month	2.00 per month

Source - American Medical Association, "Medical Service Plans", Report Prepared by the Bureau of Medical Economics, 1943, Page 29

e. Scope of Service

The benefits under this plan include all operative procedures and radiological services for diagnosis and clinical laboratory service, except what could have been performed

---

(1) Davis, op. cit., Page 19
(2) Ibid, Page 19

before admission; and injuries from obstetric causes, unless necessary to save lives.(1) A two visit deductible contract is offered to employees whereby the latter are entitled to medical service for seventy-five cents a month not including: the cost of the first two visits for any one illness, eye refractions, physical theraphy, cold shots, treatment for mental disorders, drug addiction, chronic alcoholism, intentionally self-inflicted injuries, and war casualties.(2)

A further limitation to the medical care is that each chronic condition shall receive care for a maximum of three months. Enrollment is limited to those with incomes below three thousand dollars and to groups of at least five, and one hundred per cent participation is required of all groups of less than ten persons and fifty per cent of all over ten.(3) Physicians are paid two dollars and fifty cents per visit and a proportion of the surplus.(4) The plan works in conjunction with the Hospital Service Plan of California, to provide care for farm families, defense workers, etc. and so performs a real service.

f. Problems and Conclusions

The California plan has met with a number of problems which are difficult to solve: the medical societies in different counties will not cooperate with one another; the number of subscribers is less than one per cent of the

---

(1) American Medical Association, "Medical Service Plans", a Report Prepared by the Bureau of Medical Economics,1943, Page 28

(2) Ibid, Page 29

(3) American Medical Association,"Medical Service Plans", op. cit., Page 30

(4) Ibid, Page 30

population; the amount of medical service used is greater than anticipated; and income is insufficient to pay the physicians according to the fee schedule. Consequently the California Physicians' Society had to change to surgical coverage in 1942 as did Michigan. In 1943 there were forty-five thousand subscribers, one tenth of the Michigan enrollment.(1) Thus it seems pretty evident that medical societies are unable to meet the problem of Medical Insurance. The California plan can be criticized for its income limitations (ten points), for its administration which is limited to physicians (fifteen points), for its financial arrangements which are entirely borne by the insured (fifteen points), and for its service which is good in quality (twenty points) but offers only surgical and not complete medical service (ten points), and thus should receive a rating of seventy.

4. Massachusetts

a. Origin and Development

Another good example of a Medical Society plan in action is the Blue Shield Surgical Plan in Massachusetts. As the Michigan and California Societies, the Massachusetts Medical Society has for its ultimate objective providing those with moderate incomes easy access to needed medical service on a less costly basis than at present, by means of a voluntary prepayment program. Massachusetts profited from the mistakes of the other plans and decided that it would be unwise

(1) Davis, op. cit., Page 20

to initiate complete coverage at first.

b. Eligibility and Coverage

The plan is organized on a state wide basis and has a seventy per cent participation by practicing Massachusetts physicians,(1) and eighty-eight thousand subscribers. Groups of five or over may join.(2)

c. Administration

The directorate is composed of one third subscribers, one third physicians, and one third eminent business leaders and is elected by the executive committee of the Medical Society which committee is given voting membership in the corporation.(3) Any change in the by-laws in the medical sphere by the board of directors must be reported to the voting members thirty days before definite action. The Massachusetts Medical Service has a close contractual relationship with the Blue Cross, the executive director of the Blue Cross being one of the directors of the former. This relationship is kept up because public acceptance of the Blue Cross should be an effective entry for Medical Service, because a single sales approach and payroll deduction prove more profitable, and because administration cost is reduced, etc. The Blue Cross favors an interlocking directorate but the physicians want to remain separate. However, that the

---

(1) McCann, James C., "Medical Society Prepayment Programs--Lessons Learned from the Experience in Massachusetts", Journal of the American Medical Association, Volume 126, Number 6, October 7, 1944, Page 341

(2) Faxon, Nathanial W., "Health Insurance Plans", Lecture at Harvard Medical School, February 2, 1945

(3) McCann, op. cit., Page 341

two have common interests is evident for both seek to provide service without introducing a third party between the patient and the hospital or physician, and both are attempting to make service available through prepaid contracts.

d. Financial Arrangements

Service at the regular rate is available only to individuals with incomes of under two thousand dollars and families with incomes under twenty-five hundred dollars.(1) However, those with higher incomes may be treated if they pay the physician an additional fee. It is hoped that the income limitation can be removed in time as the purpose of the plan is to cover the low income segment of the middle class group and dilute the cost of care on the basis of distribution of risk. Under the Massachusetts plan, surgical and obstetrical care is provided for at eighty-five cents per month for individuals and one dollar and sixty-five cents for husband and wife and two dollars for the family.(2) A reserve of thirty-five thousand dollars has already been collected.(3)

e. Scope of Service

Benefits include surgical service (twenty-one days per hospital admission), anaesthesia, X-rays up to fifteen dollars per hospital admission, endoscopic examinations, fifteen dollars towards consultants' fees, obstetrical care, and one hundred and fifty dollars for surgical operations.(4)

---

(1) McCann, op. cit., Page 343
(2) Ibid, Page 343
(3) Ibid, Page 343
(4) American Medical Association, "Medical Service Plans", op. cit., Page 34

Physicians are paid on a unit basis according to a schedule of surgical, obstetrical, and X-ray benefits. If funds are not available, the value of each service is reduced. Membership does not provide for services of non-participating physicians except in emergencies when the participating physicians cannot be procured. There is a waiting period for maternity cases of nine months and of twelve months for tonsillectomies for children. Subscribers with incomes over two thousand dollars may be charged by the doctor with the difference between his fee and the amount specified in the fee schedule.(1)

f. Conclusions

This Massachusetts Plan, The Blue Shield, is based upon the acceptance of responsibility by the producers of medical service. It provides a pattern which can be made universally applicable by providing care to those who need it without disrupting medical freedom. Some of the advantages of Blue Shield membership are that it is a non-profit and voluntary organization; that it gives family protection; that membership is transferable; that there are no medical examinations, nor age limits; that there are no limits to the different types of operations in any one year; that it is backed by the physicians; that it offers free choice of participating physicians; that it is approved and supervised by the state department of insurance; and that it is directed by leaders in

(1) Massachusetts Medical Society, "The Blue Shield"

the fields of industry, labor, and medicine who serve without compensation.

The directors who have been elected by the Medical Society must establish an Actuarial Research Committee and a Central Professional Service Committee. The latter determines the extent of medical benefits, the basis of compensation, standards of medical care, discipline of physicians, qualification of specialists and extension of income groups. (1) In local communities there is a district administrative unit of nine men, the majority of which including the chairman must be physicians. (2)

Because the medical profession is still in control of medical matters and laymen and consumers join in the administration, this feature deserves twenty points. The plan's income limitations reduce the value of its coverage to ten points. The fact that only surgical benefits are offered reduces the value of the services to ten points. The financial arrangements are worth only fifteen because the patient receives no help. The quality of the service is worth twenty points, making the plan worth seventy-five points in all.

5. New Jersey

a.. Origin and Development

Another interesting and slightly different state society plan is the Medical Surgical Plan of New Jersey which

---

(1) McCann, James C., "Organization for a Medical Society Prepayment Plan", Medical Care, April, 1942, Page 138
(2) Ibid, Page 138

was organized by the Medical Society of New Jersey. It was established in July, 1942 under an Enabling Act providing for the organization of non-profit medical service corporations under the supervision of the New Jersey Department of Banking.(1) The New Jersey Enabling Act says that prepayment medical service corporations must be governed by Boards of Trustees, the nomination of the members of which must be approved by a medical organization which has been incorporated for at least ten years and includes twenty thousand or more members. It also says that fifty-one per cent of the physicians eligible to practice in the area must participate.(2)

b. Eligibility and Coverage

Enrollment is restricted to employed groups covered by the hospital service plan but there is no income limitation.(3)

c. Administration

The plan is administered by a board of eight trustees nominated by the medical society.(4)

d. Financial Arrangements

If private accomodations are desired the amount allowed under the plan is credited to the patient's account, the cost to the subscriber being seventy-five cents per month for himself or two dollars for the family.(5)

---

(1) American Medical Association, "Medical Service Plans", op. cit., Page 39
(2) Klem, Margaret C., "Some Recent Developments in Voluntary Health Insurance", Social Security Bulletin, August 1942, Page 8
(3) Ibid, Page 8
(4) Ibid, Page 8
(5) American Medical Association, op. cit., Page 39

e. Scope of Service

The benefits consist of medical and surgical service during hospitalization if over three days, after a waiting period of eleven months for maternity and two months for tonsils and adenoids.(1) Drugs, appliances, oxygen, radium, blood, and conditions compensable under state or federal laws are not included. The hospital plan determines the basis and rate of payment of physicians and the relationship between physician and subscriber.(2)

f. Conclusions

As its coverage is restricted to those enrolled in a hospital plan, this feature is worth only ten points. The fact that the plan is administered entirely by the physician reduces the weight of the administration feature to fifteen points. The financing is worth only fifteen points because the burden is on the subscriber. The scope of service is limited to surgery and obstetrics and hence worth ten points. Its quality is good and deserves twenty points. Thus the plan should receive a weight of seventy.

6. General Appraisal

It is interesting to note that there are fourteen statewide Medical Society plans and seven local plans with a total membership of about one million members, one half of which are in Michigan and one fourth in Oregon and Washing-

---

(1) American Medical Association, op. cit., Page 39
(2) Ibid, Page 39

ton.(1) Most of these medical society plans are restricted in scope to surgical care and protection against high cost illnesses which are what white collar and paid industrial workers fear. The medical profession in undertaking its own health insurance program has contributed to its prestige, although many of the plans were undertaken as a defense mechanism to forestall government action. One main criticism of these plans is that the subscriber has no say in the administration and so aims to get all he can. The physicians should question subscribers as to their willingness to pay before arbitrarily setting rates. That comprehensive prepaid service can be rendered efficiently and economically through group payments has been demonstrated by industry but in the industrial plan the employer usually contributes. Organized labor would probably cooperate in medical society plans if they could share in the management.

7. Attitude of the American Medical Association

Before ending this discussion of Medical Society Plans, a word or two should be said regarding the attitude of the American Medical Association concerning the problem of medical insurance. Sixty years ago the American Medical Association advocated the establishment of a national department of Health headed by a cabinet member.(2) From 1910 through 1916 an intensive study of the whole problem was made and compulsory

---

(1) Davis, Michael M., "Health Insurance Plans under Medical Societies", op. cit., Page 21

(2) American Medical Association, "Medical Service Plans", op. cit., Page 7

insurance was opposed.(1) In 1929 state and county medical societies began to introduce plans against state medicine.(2) In 1934 ten principles were evolved(3) by the American Medical Association as their idea of what should govern American experiments in organizing medical and hospital service. These represent a good set of standards by which to measure a plan and have been followed in many instances. They are:

> "1. All features of medical service in any method of medical practice should be under the control of the medical profession. No other body or individual is legally or educationally equipped to exercise such control. 2. No third party must be permitted to come between the patient and his physician in any medical relation. All responsibility for the character of medical service must be borne by the physician. 3. The patient must have absolute freedom to choose a legally qualified doctor of medicine who will serve him from among all those who are qualified to practice and who are willing to give service. 4. The method of giving the service must retain a permanent confidential relation between the patient and a family physician. This relation must be the fundamental and dominating feature of any plan. 5. All medical phases of all institutions involved in the medical service should be under professional control, it being understood that hospital service and medical care should be considered separately. These institutions are but expansions of the equipment of the physician. He is the only one whom the laws of all nations recognize as competent to use them in the delivery of service. The medical profession alone can determine the adequacy and character of such institutions. Their value depends on the operation according to medical standards. 6. In

---

(1) American Medical Association, "Medical Service Plans", op. cit., Page 8
(2) Ibid, Page 9
(3) Orr and Walker, op. cit., Page 221

> whatever way the cost of medical service may be distributed, it should be paid for by the patient in accordance with his income status and in a manner that is mutually satisfactory. 7. Medical service must have no connection with any cash benefits. 8. Any form of medical service should include within its scope all legally qualified doctors of medicine of the locality covered by its operation who wish to give service under the conditions established. 9. Systems for the relief of low income classes should be limited strictly to those below the comfort level standard of income. 10. There should be no restrictions on treatment or prescribing not formulated and enforced by the organized medical profession."(1)

These points show clearly the definite stand taken by the American Medical Association which feels that regimentation and lay control would be fatal to the medical profession and would lower the quality of medical service and hence is against compulsory sickness insurance and for medical society plans. The association says,

> "Any scheme by which medical service can be purchased wholesale by governmental and lay organizations and distributed at retail prices to patients results in a superficial service and not only delays the conquest of disease but actually increases some forms of sickness and has not shown to be as helpful as other methods in reducing mortality."(2)

It should not be thought that medical societies have not got high standards. In 1935 the Ross-Loos doctors were expelled from the California State Medical Society on alleged charges of advertising. This clinic offered complete

---

(1) Orr and Walker, op. cit., Page 221
(2) American Medical Association, "Medical Service Plans", op. cit., Page 16

and excellent service for two dollars and fifty cents to three dollars a month and is one of the outstanding examples of a successful service sponsored by physicians. (1)

8. Conclusions

In conclusion there are medical society plans in fourteen states, California, Colorado, Georgia, Massachusetts, Michigan, New Jersey, North Carolina, Ohio, Oregon, Pennsylvania, Texas, Utah, Washington, and Wisconsin. In regard to services offered, Washington and Oregon provide physicians' care at home and in office, surgery, lab service, X-ray, physiotherapy, nurse consultant, hospital service and drugs, but no care for dependents. Most of the other states include dependents but offer much less comprehensive coverage. Forty-nine thousand people are eligible for physicians' care and four hundred and forty-five thousand for surgical and maternity benefits and twelve thousand for hospital care. (2) The average charge is three dollars a month and differs with the service offered. (3) Thus it can be seen that although Medical Society plans do not solve the problem, they contribute their bit to the total objective of complete medical care for everyone.

D. Private Group Clinic Plan--
The Ross-Loos Medical Group

---

(1) Ross, Mary, "The Care of the Ross-Loos Clinic", Survey Graphic, June, 1935, Page 300
(2) Klem, op. cit., Page 9
(3) Ibid, Page 9.

1. Eligibility and Coverage

Besides private association plans as the Blue Cross and medical society plans, private group clinics, and cooperative plans may be included in a discussion of voluntary plans.

The Ross-Loos Medical Group is perhaps the outstanding example of private group clinic plans in the country and hence is worthy of brief mention. Groups of various sizes and compositions are eligible as are non-group applicants between the ages of twenty-one and fifty. (1) There are no income restrictions; dependents are eligible at reduced rates; physical examinations are required except for males under fifty who join within ninety days after execution of a contract or within thirty days after their employment. (2) In September, 1943, there were twenty-six thousand one hundred and forty-two subscribers and seventy-one thousand dependents covered under this plan. (3)

2. Administration

The plan is administered by Doctors Allan Ross and Harry Clifford Loos.

3. Financial Arrangements

Group subscribers pay two dollars and fifty cents a month and non-group subscribers three dollars. (4) Dependents are treated at reduced fees.

---

(1) Klem, Margaret C., "Prepayment Medical Care Organizations", Federal Security Agency, Social Security Board, Bureau of Research Statistics, Memorandum Number 55, June, 1944, Page 13
(2) Ibid, Page 13
(3) Ibid, Page 13
(4) Ibid, Page 13

4. Scope of Service

Medical service from general practitioners in the clinic, office, home if within five miles of the clinic, and hospital are provided as are specialist service, surgery, maternity care and ten days a year hospitalization except for maternity cases.(1)

5. Quality of Care

The quality of acre is excellent, there being ninety full time physicians and eighty-eight registered graduate nurses.(2)

6. Conclusions

As non-group applicants under twenty-one and over fifty are excluded, the eligibility feature of this plan is worth only fifteen out of twenty as is the administration which is not in the hands of a body representing the subscribers. The financial arrangements are worth only fifteen points because the charges are high. The scope and quality of service deserve twenty points each, making a total for the plan of eighty-five.

E. Cooperative Plans of Tampa, Florida

1. General Nature--Eligibility, Administration, Finances, and Services

It might be a good idea to close this chapter on

(1) Klem, op. cit., Page 13
(2) Ibid, Page 13

voluntary plans with a discussion of a cooperative plan before turning to union and insurance plans. A Cooperative plan is one which is entirely sponsored by the consumers. In Tampa, Florida, there has been developing for fifty years a comprehensive program of medical and hospitalization services and health insurance, membership in which is open to all persons of the white race of good character and in good health. The oldest and largest is the "Centro Espanol de Tampa" which has six thousand members.(1) The objectives of the plan are to provide medical and surgical treatment and hospitalization to members, educate them, and provide a social center for them. All the members can vote. There are paid managers and a paid secretary. Dues vary with each club. The dues of the Italian Club are sixty-five cents a week and entitle the member to two dollars a day when unable to work after eight weeks of membership.(2) General Medical Care is available at once after the first payment; Eye, ear, nose, and throat specialists, medicine, electrotherapy, and laboratory examinations become available after five payments; and tooth extraction, X-ray, surgical operations, and hospitalization after six months of membership.(3) The lower the rates, the lower the cash benefits. Monthly payments in case of permanent disability are thirty

---

(1) Laird, Angus, "Cooperative Plans in Tampa." Medical Care, Volume 2, Number 3, July, 1943, Page 235
(2) Ibid, Page 235
(3) Ibid, Page 235

dollars.(1) Some clubs have their own hospital and others allow the patients to choose any in the city. Each club has a panel of salaried doctors who have regular consulting hours. Members may choose a family physician from the panel and specialists from those who have agreements with the club, but dentists are paid on a fee basis. Periodic examinations are made as a matter of prevention. The method of collection is rather unique in that collectors call at the homes of the members. The doctors are paid for part time service one hundred and fifty to two hundred dollars per month,(2) and get a month's vacation with pay.

2. Conclusions

One of the main criticisms of this plan is that the doctors are overworked. They usually have seven house and eighteen office calls a day. Another objection is to the type of medical and office service provided. It takes generations to develop an organization of this type and hence it is unlikely that they will develop on a large scale. Nevertheless, cooperative plans are permanent in Tampa.

In rating this plan, twenty points should be given for the eligibility and for the administration in which the members participate. The financial arrangements are likewise satisfactory, (twenty points). The service is only fair in quantity (fifteen points) and poor in quality (ten

(1) Laird, op. cit., Page 239
(2) Ibid, Page 240

points) making a total for the plan of eighty-five points.

As can be seen from this chapter, voluntary plans contribute much toward accomplishing the ultimate aim of complete service for everyone.

The next chapter will be devoted to a discussion of labor organization and commercial insurance company plans. These two types of plans have been grouped together because they represent plans which, although not directly sponsored by industries themselves, are more closely allied to industrial plans than the government and voluntary plans previously discussed.

CHAPTER IV

LABOR ORGANIZATION AND COMMERCIAL INSURANCE COMPANY PLANS

A. Labor Organization Plans

1. General Development

In recent years labor unions have instituted medical insurance plans as part of the benefits offered their members. On August 28, 1943 the United Automobile Workers' C. I. O. held a "Bargaining for Health" Conference in Detroit and set up a Medical Advisory Council and a Research Institute. (1) A Group Insurance Advisory Service was set up by the Greater New York Industrial Council to advise local unions. Contracts are being placed with existing agencies. (2) The Amalgamated Clothing Workers C. I. O. Union has established its own "Life and Health Insurance Company" under terms of a collective labor agreement between the union and the Clothing Manufacturers' Association. The union operates in seventeen states and serves one hundred and twenty-five thousand clothing workers and their families. It provides indemnity for illness and accident for fifteen weeks at eight dollars a week for women and twelve dollars for men. (3) The United Retail,

---

(1) Medical Care, "Union Health Activities", Volume 3, Number 4, November, 1943, Page 362
(2) Ibid, Page 362
(3) Ibid, Page 362

Wholesale, and Department Store Workers C. I. O. have set up the "Trade Union Accident and Health Association of America" and been granted a charter by the New York Insurance Department whereby medical and surgical care and hospital, maternity, and accident benefits on a cash basis of sixty per cent of the weekly income for twenty-six weeks are provided for two per cent of the weekly income.(1) The Health Conference of the Los Angeles C. I. O. Council on September 19, 1943 established a Permanent Health Division which was to provide health education among members, including training courses in nutrition and food values for wives; spokesmen for the C. I. O. on local, county, and state health agencies and voluntary agencies; medical and hospital programs for union members at low costs; and agitation for health legislation.(2) This list could be extended indefinitely but is sufficient to show that the unions are now assuming part of the responsibility of providing "Medical Insurance in Industry" as are the Government, the medical societies, non-profit associations, commercial insurance companies, private group clinics, cooperatives, and industries themselves.

Table 17 on Page 134, which shows the financial results of some of these union plans up to 1928, indicates that eleven national and international unions out of ninety-six provided sickness benefits at that early date.(3)

(1) Medical Care, "Union Health Activities", op. cit., Page 364
(2) Ibid, Page 365
(3) United States Bureau of Labor Statistics, "Beneficial Activities of American Trade Unions", Bulletin No. 465, Page 11

TABLE 17

Year of Establishment and Rate and Amount (in dollars) of Sick Benefits Paid by Eleven Unions

Union	Total Amount Paid in 1928 (in dollars)	Year Established	Rate of Payment	Period of Benefits	Remarks
Bakery and Confectionary Workers	$1,116,959	1895	$10 per week	16 weeks	
Boot and Shoe Workers		1900	$5 per week	13 weeks	After one week of sickness
Head Gear Workers	$ 96,458	1912	$7 per week $5 per week	7 weeks 7 weeks	men women
Iron, Steel and Tin Workers	$ 500,420	1908	$5 per week	13 weeks	discontinued 1926
Leather Workers			$7 per week	10 weeks	
Molders	$5,261,019	1896	$5.20 per week $7.60 per week	13 weeks 13 weeks	honorary members regular members
Pharmacists	$4,956,(1921-1925)	1900	$7.50 per week	10 weeks	discontinued 1927
Pattern Workers		1905	$4 per week	13 weeks	
Plumbers and Steam Fitters		1902	$15 per week	13 weeks	
Post Office Clerks	$ 135,733	1913	$10 per week	13 weeks	
Tailors	$ 377,326	1907	$5 per week	10 weeks	

Source - U. S. Bureau of Labor Statistics, "Beneficial Activities of American Trade Unions", Bulletin Number 465, 1928, Page 12

Many more have been established since then. As can be seen from this table, the benefits vary from four to ten dollars, five dollars being the most common.(1) These plans only provide cash benefits.

2. Union Plan--International Ladies' Garment Workers' Union

a. Origin and Development, Eligibility and Coverage

An excellent example of a typical Union plan which provides medical service as well as cash benefits is that of the International Ladies' Garment Workers' Union which has two hundred and thirty-five thousand members in one hundred and forty-one locals, twenty-six of which with one hundred and forty thousand members are located near New York, and which is not affiliated with either the A. F. of L. or the C. I. O.(2) The average annual income of dressmakers is eight hundred and eighty dollars, and sixty-nine per cent of them have from one to three dependents and twenty-eight per cent, four dependents.(3) These workers are reluctant to receive charitable care and cannot afford to wait for medical care in public clinics. It was because of this evident need and as an outgrowth of a strike of the cloak and suit makers in New York City in 1910 in which the unsanitary condition of the garment trade was the main issue, that the Union Health Center was established in 1913. First a joint board of sanitary control representing the manufacturers and

---

(1) United States Bureau of Labor Statistics, "Beneficial Activities of American Trade Unions", op. cit., Page 12

(2) Price, Leo, "Health Program of the International Ladies' Garment Workers' Union, Monthly Labor Review, Bureau of Labor Statistics, United States Department of Labor, October, 1939, Page 1

(3) Ibid, Page 1

the union leaders was formed to correct abuses in sweat shops and control sanitation in factories. Then the United States Public Health Service made a survey which revealed the problem confronting the workers and the Union Health Center was formed with Dr. George M. Price as director.(1) The purpose was to furnish the members of the International Ladies' Garment Workers' Union with adequate medical care at fees which the union could meet.(2) The plan began with limited service offering the patient the best in quality in the fields where most attention was needed, but did not attempt at first to offer care requiring a highly organized staff or a fully equipped institution. In 1917 the center was incorporated and in 1930 licensed by the State Department of Social Welfare.(3) For the first twenty-seven years, the clinic was in one room; then it occupied a four story building; and finally it attained the use of two large floors. Since 1934 the International Ladies' Garment Workers' Union has assumed full responsibility for financing the clinic, has paid its annual deficits, and has maintained a cultural department and health service for the families of members, health education being an integral part of the Union Health Center. Disease prevention is also emphasized and the social service department gives sympathetic attention to those with problems.

(1) Price, op. cit., Page 2
(2) Newman, Pauline M., "Questions and Answers", Education Department of the Union Health Center of the International Ladies' Garment Workers' Union, Abco Press Inc., December, 1940, Page 1
(3) Price, op. cit., Page 4

b. Administration

The Board of Directors, which consists of the International Ladies' Garment Workers' union vice-presidents, managers of the local unions, and a Union Health Center Committee appointed by the general executive board of the International Ladies' Garment Workers' Union, selects administrators who in turn choose professional, lay, and technical staffs.(1)

c. Financial Arrangements

The local unions maintain Sickness Insurance Funds. For a small sum in addition to regular monthly union dues, members may receive a weekly cash benefit when unable because of illness to continue working on their jobs. The worker is provided at no cost to himself with two examinations a year at the Union Health Center, which certifies the patient's eligibility for cash and other benefits.(2) Although there is a one dollar charge for further examinations and treatment, thirty-five per cent of the patients do not pay for any part of medical care, the cost being borne by the local sick benefit and relief funds. For every one dollar collected at the center in 1939, a typical year, the cost was one dollar and forty-one cents, and the balance was provided by the union.(3)

d. Scope of Service

---

(1) Newman, op. cit., Page 5
(2) Ibid,, Page 2 .
(3) Price, op. cit., Page 5

The two free physical examinations mentioned above are required for members and are given at the center by physicians who have complete control of the medical phases of the insurance. The union does not provide complete medical care nor experimental therapy but does give general examinations and treat patients unable to afford private physicians. Workers under care of private physicians may also obtain X-rays, electrocardiograms, and other diagnostic laboratory tests at nominal rates and have reports sent directly to their physicians. There is a drug store in the clinic where prescriptions may be filled for less than standard costs. Ninety physicians are employed part time by the union.(1) Their fees come from the Patients' Sickness Insurance Funds and a subsidy provided by the International Ladies' Garment Workers' Union. Table 18 on page 139 indicates the number of claims and awards and the average period of disability from 1935-1938. As can be seen, the improvement has been steady. Ordinarily the physician examines the claimant at the center and the medical administrators consider the medical report and issue a certificate to the local union containing a diagnosis, award, or denial. In 1937 when benefits were permitted for chronic and recurrent diseases, upper respiratory infections were the most frequent cause of disability and included: asthma; chronic bronchitis; pneumonia, minor infections of the ear, nose, throat, and digestive system, etc.(2) Members

(1) Price, op. cit., Page 3
(2) Ibid, Page 3

TABLE 18

Claims, Examinations, and Average Period of Weekly Disability of Insured Members in Locals of the International Ladies' Garment Workers' Union 1935-1938

Year	Number of Locals	Number of Insured Persons	Claims		Percent Denials	Number of Examinations	Average Days of Disability Per Claimant Awarded Sick Benefits
			Number	Rate Per 100 Insured Members			
1935	8	77,966	3,176	$4.07	24.53%	6,929	35.53
1936	8	74,975	3,875	$5.17	26.61%	8,071	35.93
1937	10	86,545	4,375	$5.05	12.27%	9,529	29.81
1938	13	105,867	4,693	$4.43	11.76%	12,173	35.44

Source -- Price, Leo, "Health Program of the International Ladies' Garment Workers' Union", Monthly Review, October, 1939, Page 5

in good standing in the union who are contributors to the sick benefit fund are entitled to benefits, the amount depending on the report of the examining physician. There is a definite procedure for establishing claims starting with filing the proper forms. No payments are made for gynecological conditions, venereal diseases, or injury from use of alcohol. Some groups pay for each illness, the premiums ranging from one dollar to six dollars and eighty cents a year, and the cash benefits from seven dollars to ten dollars a week.(1) The medical benefits are separate from the cash payments and entitle the member to examinations and treatment, medicines, and eyeglasses to seven dollars and a half.(2) Local #91 is a good example of the many locals which provide hospitalization benefits of one dollar and a half per day from the eighth to the twenty-first day of hospitalization at no increase in premium.(3)

e. Conclusions

As can be seen there is no definite policy covering the various locals. For a slightly larger amount than the regular union dues, the member is entitled to cash benefits for illness, the amount to be determined by the examining physician, and to clinical service. Members who are bedridden are visited by Union Health Center District physicians but when physically able, the member is required to come to

---

(1) Price, op. cit., Page 15
(2) Ibid, Page 15
(3) Ibid, Page 17

the center. The union arranges for hospitalization wherever possible. The clinic is equipped to care for all illnesses except those needing hospital, surgical, or institutional care. The medical department includes specialists in the following departments: internal medicine, diseases of women; diseases of the eye, ear, nose, and throat; skin diseases; stomach and intestines diseases; rheumatic and arthritic conditions; nervous diseases; rectal diseases; venereal diseases; tumors; orthopedics; minor surgery; and allergy.(1) The technical department consists of X-rays, diagnostic labs, electrocardiography, physiotherapy, and basal metabolism. There is also a social service department. The attendance at the clinic has been growing yearly and in 1939 was one hundred thousand.(2) Although the greatest demand for service in the clinics is from the eye clinic, eighteen per cent of the sick benefit cases requiring operations are for appendectomies, seventeen per cent of the medical cases are for heart disease, sixteen per cent for diseases of the digestive tract, and fourteen per cent for respiratory diseases.(3)

All union members are eligible so from this standpoint the plan is worth twenty points. It is administered by the union officials and so the consumers are well represented. (Twenty points) The financial arrangements also deserve twenty points. The services are limited and do not

---

(1) Newman, op. cit., Page 3
(2) Price, op. cit., Page 14
(3) Ibid, Page 14

include hospitalization nor operations. (Ten points) The quality of the service is hampered by cumbersome procedure and hence worth only fifteen points, making the total for the plan eighty-five points.

3. Union Plan--Cafeteria Employees' Union, Local 302, New York

a. Eligibility and Coverage

The medical plan of the Cafeteria Employees' Union, Local Number 302 is quite similar to consumer sponsored industrial plans and deserves brief treatment in a discussion of union plans. Union members who have been employed at least thirty days, who are between the ages of eighteen and fifty, and who have satisfactorily passed a physical examination are eligible. (1) There were in June of 1943, six thousand subscribers and seven thousand dependents. (2)

b. Administration and Financial Arrangements

This plan is administered by the consumer subscribers who pay twenty-five cents a month for themselves and reduced fees for their dependents. (3)

c. Scope of Service

General practitioner care in office and home and specialist care are offered, maternity care being definitely excluded. (4)

d. Quality of Care

The quality of care is good, only four part time

---

(1) Klem, Margaret C., "Prepayment Medical Care Organizations", Federal Security Agency, Social Security Board, Bureau of Research and Statistics, Memorandum Number 55, June, 1944, Page 59
(2) Ibid, Page 63
(3) Ibid, Page 63
(4) Ibid, Page 63

physicians,(1) being needed because of the small number of subscribers.

e. Conclusions

Because of the required waiting period and age restrictions, the eligibility and coverage feature of the plan is worth only ten points. The administration and financial arrangements and quality of care are worth twenty points each, but the scope of service being limited is only worth fifteen points, making a total of eighty-five points for the plan.

4. Union Plan--International Workers' Order

Before discussing very briefly the plans of a few minor unions, the International Workers' Order will be discussed because some of its features, particularly financial arrangements, are different from the above plans.

a. Eligibility and Coverage

All members of the International workers' Order and their dependents are eligible and there are no income, age, or examination requirements. In January, 1943, there were sixteen thousand subscribers and thirty-two thousand dependents.(2)

b. Administration

The plan is consumer sponsored and hence the administration is representative.

c. Financial Arrangements

The charges are sixty-eight cents per quarter for

---

(1) Klem, op. cit., Page 63
(2) Ibid, Page 65

subscribers and one dollar and five cents per quarter for subscribers and their dependents.(1)

d. Scope of Service

General practitioner service in office, home, and hospital is offered, two dollars extra being charged for night home calls. The patient pays reduced fees for specialist care and up to fifty dollars for major surgery. The extra charge for maternity care is forty dollars if from a general practitioner and seventy-five dollars if from an obstetrician.(2)

e. Quality of Care

The quality of care is good, there being a capable staff of physicians.(3)

f. Conclusions

The eligibility requirements which are very liberal, there being no restrictions, deserve twenty points as does the administration feature. The basic charges are reasonable but there are too many extra charges which make the financial arrangements worth only fifteen points. The scope of service being too limited is only worth ten points. The quality of care is worth twenty points. Thus the plan of the International Workers' Order deserves a rating of eighty-five points.

5. Other Union Plans

Before closing the subject of union plans, it might

(1) Klem, op. cit., Page 65
(2) Ibid, Page 65
(3) Ibid, Page 65

be well to look at the progress made by a few other unions in this line.

a. Chicago Packing House Workers Union

Twenty thousand members of the Chicago Packing House Workers Union live within a mile and a half of the stockyards and have irregular employment, and eighty and six tenths per cent earn less than sixteen hundred dollars per year. (1) The nature of their work exposes the workers to special hazards. As there are no clinics in the area and the closest public hospital is five miles away, the union decided that the only solution was to establish a hospital plan. The union cannot afford to pay for a clinic but thinks that medical care is a public responsibility and that treatment centers must be established and maintained by public agencies.

b. The Chicago Post Office Clerks Union

The Chicago Post Office Clerks Union on the other hand feels that the providing of good medical care is up to the labor union and has established a hospital committee to find out the total risk of illness and draw up a plan. (2)

c. The Chicago Teachers Union

The Chicago Teachers Union has drawn up an interesting set of principles which might well be applied to other plans: "1. Medical costs for the individual are unpredictable

---

(1) Crear, Leslie, "Chicago Packing House Workers and Their Problem of Medical Care", Medical Care, Volume I, Number 1, 1941, Page 157

(2) Petras, Lewis Petro, "Search for Health Security", Medical Care, Volume I, Number 1, 1941, Page 159

and can't be budgeted. 2. Medical cost for the group can be predetermined and spread. 3. Medical service for groups must emphasize prevention. 4. It must be furnished through group medical practice. 5. It must be voluntary. 6. It must be controlled in part by the members and medical questions must be left to physicians. 7. The union must familiarize itself with the essentials of modern medical agreements with civic medical centers."(1)

This union plans to provide diagnostic examinations, consultations, treatments at home and in the office, chemical and laboratory tests, X-rays, immunizations, major and minor surgery, and home calls. Medicine and hospitalization will be included at additional costs as will dental and obstetric care.(2) This plan would be excellent if carried out. It is interesting to note the different attitudes of these three Chicago unions.

d. The Ford Automobile Workers Union

The Ford Automobile Workers Union which is part of the United Automobile Workers Union (C. I. O.) which has a health department of its own, has a ten year contract with the John Hancock Mutual Life Insurance Company whereby medical insurance is made available to one hundred and twenty thousand unionized employees and their dependents.(3) Weekly payments of fifteen dollars are made to the insured during

---

(1) Crew, M. C.; Daniels, Elmer, "A Chicago Teacher's Union Medical Center Plan", Medical Care, Volume I, Number 1, 1941, Page 161

(2) Ibid, Page 161

(3) Medical Care, "United Automobile Workers Establish A Health Department", Volume II, Number 3, November, 1942, Page 378

disability caused by sickness or accidents; five dollars a day is paid for each day of hospital care up to seventy days; thirty dollars is paid for specialist services as X-ray and lab; surgical benefits up to one hundred and fifty dollars are paid; and life insurance of fifteen hundred dollars is provided.(1) This plan was chosen by the Ford Union instead of the Michigan Medical Service plan because the union is able to join in the administration and because the company did not want to make two separate payroll deductions. Furthermore, it is cheaper than the Michigan Medical Service Plan, the charge under the latter being six dollars per month as compared with two dollars and ninety cents under the John Hancock Plan.(2)

e. United Automobile Workers C. I. O. Union--Detroit

In Detroit, representatives of the United Automobile Workers C. I. O. Union are on the payroll of the Michigan Medical Society Plan and thus have attracted eight hundred thousand members. The union also has its own Medical Research Institute which is financed by the educational fund of the international union.(3) Although it has been necessary to give up the medical plan in favor of a surgical plan, nevertheless the union seems fairly well satisfied. This is another exampleqof how unions have attempted to meet the problem of Medical Insurance.

f. Other Unions

(1) Medical Care, "Labor Union Plans", Volume 2, Number 2, April, 1942, Page 71
(2) Ibid, Page 71
(3) Weigert, Helga, "Labor's Health Programs in Three Cities", Medical Care, Volume 13, Number 2, May, 1943, Page 109

Now that wages and hours have been controlled to a certain extent, unions are turning their attention to other activities such as health insurance. However, unionsmembers must be educated to the idea of insuring themselves as proved by the failure of the Cleveland Industrial Union Council Plan to attract enough members to make the plan pay.(1) The C. I. O. in Buffalo cooperated with the Western New York Medical Plan, but it did not work because the union was dissatisfied with the amount of control they had and because the fee of thirty-six dollars per family was too high.(2)

Thus it can be seen that there are many different types of arrangements available to unions which wish to adopt medical insurance plans. Different plans work under different circumstances, and all these plans contribute something to the ultimate objective of complete coverage.

B. Commercial Insurance Company Plans

1. Prevailing Conditions

a. Opposition to the Wagner Bill

Another important group which offers medical insurance to industrial workers is the insurance company. As can be well imagined, insurance companies oppose the Wagner Bill. The executives of a group of insurance companies expressed this general view when they said,

> "The greatest interference with private enterprise under any of the existing or proposed

---

(1) Weigert, op. cit., Page 111
(2) Ibid, Page 103

> Social Security Laws would be the proposed health insurance program. Adding accident and health and hospitalization insurance to Social Security would cause the elimination of about eighty per cent of the business now underwritten by accident and health companies, a three hundred and fifty million dollar industry. A very large percentage of the individuals who would be covered under a federal program are already covered through private insurance."(1)

Stuart F. Conrod, actuary of the Loyal Protective Life Insurance Company estimates that thirty million three hundred fifty-four thousand, nine hundred and sixty-four health and accident policies were written in 1941.(2) This is a considerable number and hence insurance companies should not be overlooked in any consideration of "Medical Insurance in Industry". Table 19 on page 150 indicates the distribution of these policies according to various different types which can be differentiated as follows: commercial insurance includes adequate cash benefits for temporary disability up to a year at an annual premium of about twenty dollars; non cancellable insurance covers risks of permanent and temporary disability and offers cash benefits over a generous period of time even though physical standards are high, the annual premium being fifty dollars; both are purchased almost exclusively by white collar workers;(3) Limited business policies cover for the most part only specified accidents and are purchased largely by white collar

---

(1) Clark, Katherine G., "Insurance Companies and the Wagner Bill", Medical Care, Volume 3, Number 4, Page 303
(2) Ibid, Page 304
(3) Ibid, Page 304

workers; These first three policies serve only a fraction of the people among the upper income classes but constitute forty-one per cent of the total; Monthly and weekly premium insurance constitute eighteen per cent of the total, the monthly providing long benefits at an annual premium of eighteen dollars and being sold chiefly to high wage earners, and the weekly being sold chiefly to low wage earners and being held by a larger proportion of people;(1) Group insurance is for industrial wage earners;(2) A contract is made with the employer covering the employees for accident and sickness, hospitalization, surgical fees, and accidental death and dismemberment; The wage earners with whom the Wagner Bill is concerned buy mainly this type, over twelve million policies having been sold in 1941.(3)

TABLE 19

Insurance Company Medical Policies 1941

Type	Number	Per Cent of Total
Commercial	4,978,348	16.4%
Non Cancellable	463,850	1.5%
Limited Business	7,083,145	23.3%
Monthly Premium	1,300,156	4.3%
Weekly Premium	4,139,346	13.7%
Group	12,390,124	40.8%

Source - Clark, Katherine G., "Insurance Companies and the Wagner Bill", Medical Care, Volume 3, Number 4, November, 1943, Page 304

b. Financial Arrangements

As to the financial arrangements of a typical group

---

(1) Clark, op. cit., Page 304
(2) Ibid, Page 304
(3) Ibid, Page 304

insurance policy, a basic annual premium of seven dollars and twenty cents entitling the insured to ten dollars a week for thirteen weeks is common.(1) In 1941, one hundred and sixty million dollars, which was fifty per cent of the amount collected and five per cent of the total cost, was paid out in benefits.

c. Cash Benefits

All benefits are in cash and compensate the insured for wage loss rather than the expense of medical care except those policies covering hospital and surgical fees. There is usually no coverage for dependents except in the latter case and coverage for total disability is limited.

d. Conclusions

In individual insurance, the coverage is often lost if the place of work is changed, premiums are determined by the likelihood of sickness, and those who need the insurance most can least afford to pay for it. In group insurance none of these conditions exist as special risks can be merged in general distribution by adjusting premiums to age, sex, and race. Tables 20 and 21 on pages 152 and 153 show the coverage of various group insurance policies and commercial and cooperative policies. More than thirty-one million wage earners hold insurance company policies providing some sort of coverage against disability.(2) The benefits

---

(1) Clark, op. cit., Page 308
(2) Ibid, Page 309

TABLE 20

Combined Group Insurance Statistics of Eight Leading Carriers 1933

Kind of Group Insurance	Number of Policies in Force	Number of Employees Insured	Average number of Employees per Policy	Amount of Insurance		Average Benefit per Emloyer in Dollars	Percentage 1933 Sales are of Total in Force
				Sold in 1933 in Thousands of Dollars	Total in Force in Thousands of Dollars		
Group Life	15,125	4,487,377	297	$343,747	$8,216,775	$1,828.00	4.2%
Group Accidental Death and Dismemberment	1,764	505,278	289	$ 96,784	$ 744,129	$1,473.00	13.0%
Group Accident and Health	4,475	1,228,918	252	$ 1,884	$ 15,974	$ 13.00	11.8%
Group Annuities and Pensions	226	193,796	4,150	$ 1,651	$ 8,435	$ 43.53	19.6%

Source - Millis, Harry Alvin, "Sickness and Insurance", University of Chicago Press, Chicago, Illinois, 1937, Page 23

TABLE 21

Estimated Cash Benefit Payments for Sickness in the United States in 1935 Through Voluntary Insurance Plans

Classification of Insurance	Benefits in millions of dollars
Total	$202.2
1. Commercial Insurance	
A. Purchased Chiefly by persons with moderate or comfortable incomes:	
Temporary Disability--Accident and Health Departments	$ 24.3
Stock Casualty and Surety Companies	$ 33.5
Mutual Benefit and Assessment Companies	$ 18.5
Permanent Disability--Ordinary Life Insurance	$ 68.6
B. Purchased Chiefly by wage earners:	
Temporary Disability--Industrial Life, Accident and Sickness	$ 9.3
Group Life, Accident and Sickness	$ 11.0
Permanent Disability--Industrial Life Insurance Companies	$ 2.2
Group Life Insurance	$ 12.0
2. Cooperative Insurance	
A. Purchased Chiefly by persons of moderate income	
Temporary and Permanent Disability--Fraternal Societies	$ 9.0
B. Purchased Chiefly by wage earners	
Temporary or Permanent Disability	
Employees Mutual Sick Benefit Associations	$ 10.0
Trade Union Sick Benefit Associations	$ 4.3

Source - Otey, Elizabeth, "Cash Benefits Under Voluntary Disability Insurance", Social Security Bulletin, Volume II, February, 1939, Page 32

are small in comparison to the total need and administrative expense is too high, individual insurance being particularly expensive. Although group insurance is more sound in regard to efficient operation and adequacy of benefits, it does not meet the problem of labor mobility. Among the costs of medical care, only those for hospital and surgery are insured against, and many employees are not covered, particularly those of small concerns. Nevertheless many people receive some type of coverage who would otherwise receive none. If insurance by commercial companies in general were to be evaluated, twenty out of twenty points should be allowed for eligibility and coverage which is open to all members of a group, ten for administration which is entirely in the hands of the company, ten for service as only limited cash benefit is provided, twenty for financial arrangements, and twenty points for quality which is normal as in private practice, making a total of eighty.

2. The Prudential Insurance Company of America Plan

a. Origin and Development

The plans offered by the Prudential Insurance Company of America serve as good examples of commercial insurance company plans. From the standpoint of the employer,

> "a group insurance plan is an investment in employee good will. It builds employee self-confidence by removing the fear of an unprepared future. The self-confidence promotes efficiency, increases production, and improves quality. It improves employee morale and engenders loyalty and cooperation. It offers employees needed protection at a low group rate either on a cooperative or an 'employer-pay-all'

> basis. The employer's costs can under certain circumstances be construed as an 'allowable business expense' for income tax purposes."(1)

The above statement summarizes fairly well reasons an employer might have for instituting a group health insurance plan. The Prudential Insurance Company offers plans providing against death from any cause, loss of salary due to sickness, loss of salary due to accident, loss of sight or limb due to accident, hospital expenses, and surgical expenses. As other insurance companies, it does not provide insurance to pay for doctors' bills. According to insurance companies' actuarial figures, about thirty per cent of employees lose time each year through sickness and ten per cent are disabled for six consecutive weeks or more;(2) one person in fifteen disabled each year requires hospital confinement;(3) and about eighty per cent of employees confined in hospitals have surgical operations.(4) Thus the need for accident, sickness, hospital, and surgical insurance for employees and their dependents is evident.

b. Eligibility and Coverage

The eligibility and coverage of the Prudential plan is broad. Full time employees of any one employer constitute insurable groups under the Accident and Sickness Insurance and the Employee Hospital Expense Insurance. The Employee Surgical

(1) The Prudential Insurance Company of America, "Highlights of Prudential Group Insurance"
(2) Ibid
(3) Ibid
(4) Ibid

Expense Insurance may be written only in conjunction with one of these other two plans. Dependents Hospital Expense Insurance and Dependents Surgical Expense Insurance cover dependent wives and unmarried children of employees and may be written only in conjunction with Employee Hospital Expense Insurance on groups having at least fifty male employees.(1) The minimum number to be insured is at least seventy-five per cent of the eligible employees (or dependents thereof depending on which plan) but not fewer than fifty; the only age limit is that for unmarried children who must be between the ages of three months and eighteen years to be eligible; and there are no medical requirements for employees who enroll themselves or their dependents within thirty-one days after the date they could first be insured.(2)

c. Administration and Financial Arrangements

The administration is quite naturally in the hands of the insurance company. The rates for the Employee Accident and Sickness Insurance and the Employee Hospital Expense Insurance are based on the plan selected, the sex and race of the employees, and the nature of the business. Under the former plan, the minimum standard rate for the plan providing benefits beginning the eighth day of disability and continuing for a maximum of thirteen weeks is sixty cents monthly per ten dollar weekly benefit; under the latter plan the rate is ten cents

---

(1) The Prudential Insurance Company of America, "Highlights of Prudential Group Insurance"
(2) Ibid

per one dollar daily benefit for thirty-one days; (1) Under the Employee Surgical Expense Insurance it is forty cents for a maximum payment of one hundred and fifty dollars. (2) The Dependents Hospital Expense Insurance costs twenty cents to thirty-three cents per one dollar daily benefits for thirty-one days depending whether or not maternity benefits are included and the Dependents Surgical Expense Insurance one dollar and forty cents to two dollars for a maximum payment of one hundred and fifty dollars. (3) Employees may pay all or any part of the cost. Where cost to the employee is relatively high, an employer contribution may be required as in Iowa where the employer must pay five cents a month for each employee. (4) That portion of the premiums not needed for the operation of the business is returned annually as dividends beginning at the end of the first year.

d. Cash Benefits

Benefits naturally vary with the plan. The Accident and Sickness Insurance provides a weekly benefit for disability caused by accidents occurring away from work or for sickness not covered by workmen's compensation which amounts to two thirds of the employee's salary but not more than forty dollars weekly. (5) Under the Employee and Dependent Hospital Expense Insurance a payment of from five to ten times the daily

---

(1) The Prudential Insurance Company of America, op. cit.
(2) Ibid
(3) Ibid
(4) Ibid
(5) Ibid

benefit is made to help cover the hospital charges for room, board--four dollars to six dollars a day--and all other services, and for confinement caused by an accident away from work or by sickness not covered by workmen's compensation.(1) These benefits are extended three months after termination of insurance if disability began while insurance was in force, nine months extension being offered in the case of child birth.(2) Benefits under Employee and Dependent Surgical Expense Insurance include payment of surgeon's fees up to an amount shown in a Schedule of Operations, which specifies maximum payments for various operations, and may be extended under the same conditions as the hospital expense insurance.(3)

e. Conclusions

In conclusion, as far as eligibility is concerned, this plan deserves twenty points. The administration is by the insurance company and hence only worth ten points. The financial arrangements are excellent and shared by employer and employees, a refund being given at times. (Twenty points) The benefits though fairly broad in scope consist only of cash and do not provide payment for medical care outside of the hospital and so are only worth ten points. The quality of service offered is normal as in private practice and worth twenty points, making a total of eighty points for the plan.

The plans of insurance companies definitely have a place in "Medical Insurance in Industry". As is the case in

(1) The Prudential Insurance Company of America, op. cit.
(2) Ibid
(3) Ibid

most types of insurance there are arguments both for and against them. On one hand, they have a definite cost, the risk is borne by the carrier, the company and the employees are protected, the financial responsibility is not the employer's and because of increased coverage is distributed more widely, and the restrictions are impersonal. On the other hand, there is a danger of impersonal injustice, delay, smaller benefits, higher costs, and no direct contact.

Now that government, private non-profit association, medical society, group clinic, cooperative, union and insurance company plans have been discussed, plans sponsored by industries and their employees both jointly and severally will be considered. As this problem is quite complex, the next chapter will introduce the general problem of industrial insurance which will be discussed in greater detail in Chapters VI, VII, and VIII. Chapter IX will be devoted to general conclusions.

CHAPTER V

PLANS SPONSORED BY INDUSTRIES, THEIR EMPLOYEES, OR BOTH

INTRODUCTION

A. Need

As described in the Introduction in Chapter I, there is much too much sickness prevalent and measures must be taken to alleviate this condition. The inadequacy has such an important bearing on the desirability of industry's establishing medical insurance plans that a few additional figures substantiating the need will be given in this chapter. American opinion on the structure and economy of this situation is divided into three groups: the standpatters, the advocates of compulsory reform via federal legislation, and the advocates of voluntary reform by cooperative groups.(1) Federal Legislation, voluntary group insurance, union, and insurance company plans have been discussed in Chapters I-IV above. Industrial Insurance Plans however constitute a large field and deserve a good deal of consideration. The armed forces have absorbed one third of all the active United States doctors. According to a survey made by Fortune Magazine, thirty per cent of the older doctors in uniform want full time post war jobs in government service, fifty-three per cent of the doctors of all ages

---

(1) Fortune, "United States Medicine in Transition--Growing Trend Toward a Compulsory Federal Insurance Law", Volume 30, Number 6, December, 1944, Page 156

want the group form of private practice, and sixty-three per cent prefer practice other than the traditional form of solo practice on the fee for service basis. (1) It is the fifty-three per cent who want the group form of private practice that the following chapters are mainly concerned with, as most industrial plans are serviced by doctors working in groups. As a matter of fact, the practice of medicine may be considered a trade and was so recognized by the United States Supreme Court which said in 1936,

> "The licensed monopolies which professions enjoy, constitute in themselves severe restraints upon competition. There is sufficient historical evidence of professional inadequacy to justify occasional protests. The better educated laity of today questions the adequacy of present day medicine."(2)

The people of the United States lose one and a half million man years of work annually through sickness. (3) Thirty to fifty per cent more mothers and infants in the first month die than would if all got good medical care. (4) Thirty thousand cancer victims a year could be saved. Thirteen million examined for the draft were rejected for medical reasons. (5) It is evident from these figures alone that too few Americans are getting the needed medical care. Doctors and hospitals are not always available as evidenced by the fact that in 1940 there were one hundred and seventy thousand

(1) Fortune, op. cit., Page 156
(2) Ibid, Page 157
(3) Ibid, Page 157
(4) Ibid, Page 157
(5) Ibid, Page 157

licensed physicians in the United States, less than one to every seven hundred and forty-eight persons. These were unevenly distributed, there being one to every four hundred and eighty-seven New Yorkers as compared with one to every fifteen hundred and one Mississippians. (1) The same is true of hospitals, there being one to every one hundred and ninety-six in New York and one to every six hundred and sixty-seven in Mississippi. (2) There are thirteen hundred counties with seventeen million inhabitants which have no medical facilities and where facilities are available, not all can use them. According to the Committee on Costs of Medical Care, the average cost in 1933 per person was twenty-five dollars and thirty cents. (3) Dr. Samuel Bradbury estimated it at sixty-six dollars and ninety-seven cents in 1937, (4) and so it probably lies somewhere between these two figures. According to the National Health Survey in 1935, ninety per cent of the population could not pay for adequate medical and hospital care by fee for service methods. (5) This condition has improved somewhat in the past few years but is still bad. Industrial plans cannot cure the evil of unequal distribution of medical care which will have to be accomplished by some sort of incentive to physicians in the form of assured working facilities and income in the rural areas

(1) Fortune, op. cit., Page 157
(2) Ibid, Page 157
(3) Ibid, Page 157
(4) Ibid, Page 157
(5) Ibid, Page 157

perhaps through government compulsion. However, industries can contribute a great deal toward making the costs of medical care more bearable by introducing insurance plans offering cash benefits, medical services, or both either at no cost to the employee or at fixed predetermined costs which can be made low because of the distribution of risk principle. That industries are doing something in this direction is evidenced by the fact that there are today two hundred and ten voluntary plans covering twenty million people.(1) There are an infinite variety of plans offered by industrial establishments. Some sell the services of individual doctors and others the services of groups of doctors; some offer complete preventive, diagnostic, and therapeutic, medical and surgical care in the home, office, and hospitals while others offer only cash benefits or hospitalization benefits; some take care of the employees of a single corporation and others include everyone in a certain area; some include individual employees and others their dependents; doctors may be paid on the fee for service, per capita, or salary basis and employees may pay the whole bill, part of it, or nothing. These plans will be classified, exemplified, and discussed in the following chapters, as described in the closing sections of this chapter.

B. Opinions

1. Favorable Industrial Opinions

Before classifying the plans to be discussed, it

---

(1) Fortune, op. cit., Page 160

might be well to consider the opinions of a few prominent industrial, medical, and political leaders on the subject. Following are a few excerpts from some favorable statements of executives of companies cooperating with employees in group insurance programs:

Mr. Knôx Ide, president of the American Home Products Corporation says of their group insurance program,

> "I maintain that industry must provide this 'Better Medical Care' for its employes and for their families. I believe it is industry's moral responsibility to do so. On the basis of my own company's experience I know that industry can profit from it, employes and their families can profit from it, and the Nation as a whole can profit from it since a large part of the medical care problem will have been solved.
>
> An employe's worries cut down his working efficiency. This health insurance plan removes his worries about the costs of medical care. Without these worries he works better, produces more, and takes a greater interest in his job. His greater production increases company profits. Out of these increased profits, the company can well afford and is glad to pay a large share of the cost of the insurance. The money we spend in carrying the company's share of the premium cost is one of the most profitable investments we make."(1)

Mr. John G. Searle, President of the American Drug Manufacturers Association says,

> "To me a hospitalization, surgical fee and sickness insurance plan is a 'must' for everyone in our industry. It should also be very definitely a part of our individual plans to see that such insurance receives wide publicity and acceptance by all industry. We are only acting for our own selfish interests when we carry out such a program. We are only protecting the future of our business in seeing that the great majority of the working people and their families

---

(1) National Physicians Committee for the Extension of Medical Service, "Opportunity for Private Enterprise or Benefits for Business through Cooperative Group Insurance", Page 34

are covered by such plans."(1)

The Black and Decker Manufacturing Company of Towson, Maryland, says,

> "We are of the opinion that our employes appreciate the opportunity of getting group insurance and hospital coverage at a nominal cost, and believe that employer-employe relationship is more cordial because the employes have been given this opportunity."(2)

The Buck Hill Falls Company of Pennsylvania says,

> "Unless industry devises its own system of adequately protecting the medical welfare of its workers, this country will have a politically operated type of socialized medicine imposed upon it."(3)

The Henry Bower Chemical Manufacturing Company of Philadelphia, Pennsylvania, says,

> "It is our feeling that the cost of an insurance program should be borne by the employe. In a broad sense we believe that employe insurance plans have a good economic and social effect in industry."(4)

C. W. Grifford, President of the Des Moines Railway Company says,

> "Results are intangible. However, for the long pull I believe they are favorable---certainly right from a social standpoint. The true answer is, they are necessary from a labor-relations angle, so why quarrel with need or results."(5)

Earl G. Downs, Personnel Director of the Fostoria

(1) National Physicians Committee for the Extension of Medical Service, op. cit., Page 33
(2) Ibid, Page 35
(3) Ibid, Page 36
(4) Ibid, Page 36
(5) Ibid, Page 37

Glass Company, Moundsville, West Virginia, says,

> "It builds up individual efficiency by making it possible for the employe to have some physical defect corrected before it develops beyond repair. The employe has less financial worry during illness and is usually more efficient when he returns to work."(1)

W. B. Place, Personnel Manager of the Kieckefer Container Company, Delair, New Jersey, says,

> "General level of health has improved to such an extent that several reductions in weekly premiums have been made. We attribute this to the fact that insured employes are less likely to return to work before they are completely recovered, and to the opportunity insurance claims afford our medical staff to offer advice on good health habits and the value of preventive measures."(2)

Lothair Teeter, President of the Perfect Circle Company, Hagerstown, Indiana, says,

> "We are completely 'sold' on group insurance for employes of our company. It affords a practical, sane and humanitarian approach to the problem of protection against the unforeseen risks which every wage earner faces. We believe in privately financed plans instead of government-sponsored, politically-influenced programs. The only way to head off the socialistic trends in this field is to provide the means of achieving the same beneficial results through voluntary group action. Group insurance definitely promotes good industrial relations."(3)

It can be seen that these nine executives favor Group Health Insurance because it:

---

(1) National Physicians Committee for the Extension of Medical Service, op. cit., Page 37

(2) Ibid, Page 38

(3) Ibid, Page 40

(1.) Removes employees' worries about the costs of medical care and helps increase production;

(2.) Protects the future of the business;

(3.) Improves employer-employee relations;

(4.) Prevents socialized medicine;

(5.) Has good economic and social effect on industry;

(6.) Is necessary from the labor relations angle;

(7.) Provides correction of physical defects;

(8.) Improves health;

(9.) Promotes good industrial relations.

There are many more reasons favoring medical insurance but this sample is sufficient to show what the majority of employers with such systems think.

2. Unfavorable Industrial Opinions

However, there have also been some unfavorable comments of which the following are a few samples:

> An Illinois Lamp Company says, "Only less than ten per cent appreciate anything you do for them. This condition may change after the war, but right now it is a total loss."(1)
>
> A Montana Mining Company says, "The weakness of the plan, as adopted here, seems to be that the Company pays the entire premium. The employes who have benefited by it appear to be appreciative. Those who have not benefited by it seem to take it for granted that if the Company pays the entire premium it is getting greater advantages otherwise. It would appear that nonparticipation by employes in the payment of premiums comes under the general head of getting

(1) National Physicians Committee for the Extension of Medical Service, op. cit., Page 41

> something for nothing, which is never appreciated."(1)
>
> A Missouri Heating Company says, "I question whether an insurance program is of the slightest advantage to the Company in the way of morale building because once it is established employes take it for granted, they give it no thought and give the Company no credit. It has, in no way, affected the percentage of time that is loafed away."(2)
>
> A Pennsylvania Glass Company says,"Absenteeism has been encouraged by and thru the payments of benefits. Our experience in these matters is that the employe very quickly assumes an attitude that the company owes him such things as Group insurance. In a recent survey which we made, we were very much surprised to find that the average employe did not appreciate the fact that the company was paying a substantial part of the premium."(3)

These four examples of unfavorable executive opinions are sufficient to show that the main objections seem to be that the insurance is not appreciated but taken for granted and that absenteeism is encouraged through payments of benefits. However there is more to be said in favor of "Medical Insurance in Industry" even though the following are obvious gaps in present plans: (1) too large a group is required to obtain minimum cost; protection may terminate with employment; and there is no provision for unusual illnesses.(4) These defects will be corrected in time.

3. Opinions of the Surgeon General of the United States Public Health Service and the National Physicians Committee for the Extension of Medical Service.

The National Health Program of Dr. Thomas Parran,

---

(1) National Physicians Committee for the Extension of Medical Service, op. cit., Page 41
(2) Ibid, Page 42
(3) Ibid, Page 42
(4) Ibid, Page 10

the Surgeon General of the United States Public Health Service, and that of the National Physicians Committee for the Extension of Medical Service form an interesting contrast as can be seen from the brief description below. The National Physicians Committee favors industrial plans as described in the following chapters whereas Dr. Parran advocates a national plan.

a. National Health Program of the 'National Physicians Committee for the Extension of Medical Service'

> "If state medicine is to be avoided, if the 'political control' of the distribution of medical care is to be prevented, if the independence of the medical profession is to be preserved, the needs of the people must be met.
>
> The task is of such size that meeting the need will tax to maximum capacity all agencies and institutions now providing or that can be created to provide measures of relief. These include:
>
> a. Physician-sponsored prepayment medical care programs;
> b. Blue Cross Hospitalization Plans;
> c. Independent physician groups furnishing medical service;
> d. Industrial or business concerns providing medical care for workers;
> e. Employer-employe Group Insurance Programs."(1)

b. National Health Program of Dr. Thomas Parran, Surgeon General of the U. S. Public Health Service

> "Steps which should be taken toward a comprehensive national health program:
> 1. We should find the means to finance the costs of medical care for every individual--through tax-supported programs, health insurance, or a combination of both.
> 2. Tax funds should be made available through grants-in-aid to the states for the construction of hospitals and health centers.

---

(1) Davis, Michael M., "Statesmen Discover Medical Care", Survey Graphic, Volume 34, Number 3, March, 1945, Page 102

> 3. To insure adequate numbers of health and medical personnel, tax funds should be made available for the expansion of professional education.
> 4. We should provide for the application of all the knowledge we have to prevent disease--through full time public health departments in every part of the country and the addition of such services as industrial hygiene, public health nursing, children's dentistry, mental hygiene, and nutrition.
> 5. The nation should continue to support and encourage both public and private research in the medical sciences through grants-in-aid to qualified institutions.
> 6. We should meet the present deficiencies in the nation's sanitary facilities through the construction of public water supplies, sewerage systems, and the like."(1)

4. Opinions of Physicians and Medical Administrators (2)

a. Dr. I. S. Falk

Dr. I. S. Falk indicated that most sickness and deaths result from uncontrollable causes (3) and that more attention should be paid to preventive services. This might well be considered as a goal toward which industrial plans should strive.

b. Dr. Nathan Sinai

Dr. Nathan Sinai stressed diagnostic, curative, and preventive services as all being important and said that plans "must be flexible enough to permit full utilization of the services that exist in different communities or areas of the country." (4) He indicated that many of the expenses of

---

(1) Davis, op. cit., Page 102
(2) Physicians' opinions not quite so closely related to industrial plans may be found in Chapter I
(3) Falk, I. S., "Content and Administration of a Medical Care Program", American Journal of Public Health, Volume 34, Number 12, December, 1944, Page 1224
(4) Sinai, Dr. Nathan, "Content and Administration of a Medical Care Program", American Journal of Public Health, Volume 34, Number 12, December, 1944, Page 1232

plans are not new and advocated central financing within trade areas. His ideas might also be used by those forming industrial plans.

c. Dr. J. Roy Hege

Dr. J. Roy Hege believes that the majority of the ten to twenty members of policy forming boards should represent the public, (1) and that only a minority should represent the medical and dental professions and hospitals and advocates the institution of courses in health insurance, public administration, hospital administration, etc.

d. Graham Davis

Graham Davis suggests that physical facilities as hospitals, health centers, and laboratories be extended. (2)

e. George St. J. Perrot

George St. J. Perrot stresses the importance of the training and distribution of personnel and the extension of research by means of scholarships, grants for postgraduates, education, of health and medical personnel, grants for the promotion of postgraduate education, grants for new training, facilities, etc. (3)

5. Political Opinions

Before leaving this discussion of opinions, it

---

(1) Hege, Dr. J. Roy, "Content and Administration of a Medical Care Program", American Journal of Public Health, Volume 34, Number 12, December, 1944, Page 1235

(2) Davis, Graham, "Content and Administration of a Medical Care Program", American Journal of Public Health, Volume 34, Number 12, December, 1944, Page 1239

(3) Perrot, George St. J., "Content and Administration of a Medical Program", American Journal of Public Health, Volume 34, Number 12, December, 1944, Page 1245

might prove interesting to note those of some political leaders. As mentioned before, the late President Roosevelt included as basic freedoms "adequate medical care" and "the right to achieve and enjoy good health."(1) In his 1944 campaign, Wendell Willkie said,

> "Complete medical care should be available to all. In any program the value of the practicing physician's relationship to his patient must be recognized. Adequate provision must be made for building hospital facilities and for research and medical education."(2)

Henry Wallace in a statement to the Senate Commerce Committee said,

> "Your federal and state governments have just as much responsibility for the health of their people as they have for providing them with education and police and fire protection...We must see that medical attention is available to all the people. But this health program must be achieved in the American way. Every person should have the right to go to the doctor and hospital of their own choosing. The federal and state governments should work hand in hand in making health insurance an integral part of our social security program just as old age and unemployment benefits are today. We need more hospitals and doctors.We should make sure that such facilities are available.. We must not be content to provide medical attention for people after they become sick...The government should appropriate needed funds to finance...medical research in private and public institutions."(3)

Senator Claude Pepper said, "Unfortunately American Medicine at its best reaches only a small part of the population."(4) He also said,

---

(1) Davis, Michael M., "Statesmen Discover Medical Care", Survey Graphic, Volume 34, Number 3, March, 1945, Page 101
(2) Ibid, Page 101
(3) Ibid, Page 101
(4) Ibid, Page 101

> "Evidence...leads the subcommittee to conclude that the 'pay-as-you-go' or fee-for-service system which is now the predominant method of payment for medical services, is not well suited to the needs of most people or to the widest possible distribution of high quality medical care. It tends to keep people away from the doctor until illness has reached a stage where treatment is likely to be prolonged and medical bills large. It deters patients from seeking services which are sometimes essential, such as specialist care, laboratory and X-ray examinations, and hospitalization. Individuals with low incomes, whose need is greatest, are most likely to postpone or forgo diagnosis and treatment."(1)

These opinions are sufficient to indicate the general trend of thought. The goals and achievements of industrial plans are interesting to note in passing.

C. Goals and Achievements

A complete group insurance plan might consist of the benefits listed in Table 22 on Page 174.

For dependents, identical coverage should be provided for hospitalization, surgical, and medical care. As can be well imagined all companies do not offer complete programs such as this. However, this is a good goal for industries to strive to reach and unless it is attained the government will eventually step in and take control. That plans such as these are beneficial to the employee can be shown from the cost angle alone. Mr. S. Dewitt Clough, President of the Abbott Laboratories, estimates that the cost to the employee of their group insurance is from one seventh

---

(1) Davis, Michael, op. cit., Page 101

TABLE 22

Complete Insurance for Employees

Type	Description
Life Insurance	Equal to approximate annual earnings.
Sickness Benefits	Equal to 25% to 50% of weekly wage.
Hospitalization	From $4 to $7 per day in hospital.
Hospital Extras	From $20 to $35 per illness.
Surgical Costs	Basic fee schedule--maximum $150
Medical Care	With fixed maximum benefit
Retirement Annuity	Based on service and earnings.

Source - National Physicians Committee for the Extension of Medical Service, "Opportunity for Private Enterprise or Benefits for Business through Cooperative Group Insurance", Page 10

to one third that for comparable coverage under individual policies and attributes this to the spreading of the risk over a large group, one group sale instead of many individual ones, and one point of claims instead of many. (1) That employees realize this is evident from the fact that of the twenty-two per cent of the nation's people who are employed by industries providing insurance, sixteen per cent have taken advantage of such opportunities, and forty-one per cent are interested in having insurance coverage. (2) More than seventeen thousand businesses and industrial firms provide medical insurance and ninety per cent of these have found it a profitable investment. (3) In 1943, there were in effect group policies covering more than twenty-five million people and representing a gross volume of more than twenty-five

---

(1) Davis, Michael, op. cit., Page 8
(2) Ibid, Page 11
(3) Ibid, Page 13

billion dollars.(1)

The goals of industrial plans are similar to, if not identical with, the objectives of the American Public Health Association as expressed by its subcommittee on Medical Care which wrote,

> "The objective of a national medical care program should be to make available to the entire population, regardless of the financial means of the individual, the family, or the community, all essential medical services. Such services must be of high standard and rendered under conditions acceptable to the public and the professions concerned. In scope they should include hospital care, the services of physicians, laboratory and diagnostic services, nursing care, essential dental services, and prescribed drugs. Because of inadequacies of personnel and facilities, all of these measures cannot be provided immediately to the whole population, but their complete development within ten years may be taken as a goal. Regardless of temporary shortcomings, a beginning should be made now in the provision of services to the extent that available personnel, facilities, and administrative techniques make possible. Later, but as rapidly as possible, the program should be expanded to the intended scope."
>
> "An achievement of the objectives of a national medical care program," the subcommittee thought, "would require simultaneous attack on five main fronts; namely, distribution of costs, development of administrative organization to provide the service, training of personnel, construction of facilities, and improvement of knowledge."(2)

This subcommittee advocated financing the program by compulsory Social Insurance contributions supplemented by general taxation. It favored decentralized operation and central administration and urged that physical facilities be improved, that research opportunities be provided, and

---

(1) Davis, Michael, op. cit., Page 24
(2) Moulton, Joseph W., "Content and Administration of a Medical Care Program", American Journal of Public Health, Volume 34, Number 12, December, 1944, Page 1218

that agencies expecting to carry major responsibilities in such a program begin preparing now. All these objectives and suggestions might very well be applied to Industrial Plans also. In fact the above mentioned subcommittee indicated that medical service should follow the lines of trade areas (1) not political subdivisions.

With this information as to the needs for "Medical Insurance in Industry", opinions of executives and others as to its value, and the goals and achievements as a background, it might be advisable to turn now to a classification of the industrial plans to be discussed and then to a description of the plans themselves.

D.. Classification of Plans

> Gerhard Hirshfield said: "It is sometimes maintained that 'wishful thinking' has preceded every brilliant economic advance; the telephone, the radio, the phonograph, the automobile, the aeroplane, and the electric light. But between wishful thinking and the finished product of our inventors lay a mountain of experimenting, planning, testing, checking, losing, speculating, trying again, and finally achieving. If our social planners would adopt the tested formula of our pioneers and inventors, one could be assured ultimately of a system of social security as perfect as man can make it, and satisfactory to most persons."(2)

The following three chapters are devoted to a description of eighteen plans sponsored by the industries them-

(1) Moulton, op. cit., Page 1220
(2) Hirshfield, Gerhard, "Social Security--Past, Present, and Future", American Taxpayers Association, Washington, D. C., 1944, Page 23

selves, the employees thereof, or a combination of the two. These three types of plans each fall into two general classifications, cash benefit plans and service plans. As long as the costs of illness remain uncertain and unprovided for, the effectiveness of other security programs is seriously impaired, because loss of income and expenses occur at the same time. Nevertheless private plans for sickness benefit do cover limited groups and hence are helpful. It is questionable whether or not the total problem can be solved by industrial plans but they contribute a great deal and if extended to more industries would be more useful. Often employees stay at work as long as possible and allow minor ailments to develop into serious complications. The illness of one frequently affects the output of many and yet many companies have no formal plan and individuals must be helped by passing the hat.

1. Cash Benefit Plans

As mentioned before there are three main types of cash benefit plans used by industries: (1) non-contributory plans financed and managed by the company in which the employee receives part of all of his regular earnings for a specified maximum length of time which varies with service and in which administration is simplified and authority centralized; (2) joint employer-employee plans in which the company and the employee join in providing funds and handling and disbursing them, the company sometimes contributing an equal amount, and sometimes the cost of organization and

administration and the employees sharing in the administration and therefore having greater interest and a sense of responsibility; (3) mutual benefit associations of employees.

a. Non-Contributory Plans Financed by the Company

Non contributory plans can be afforded only by large companies, and so for smaller companies, it is better to institute group sickness insurance on a prepayment basis. Many non contributory plans are administered as part of pension plans and some vest the management in Employee Benefit Committees appointed by the Board of Directors. There is usually a service requirement which must be met by the employee before he becomes eligible and also a waiting period after illness starts before benefits begin. This waiting period is supposed to eliminate unimportant illnesses and reserve the company help for more serious cases. Benefits which sometimes take the form of a flat sum and othertimes a stated proportion of wages for a specified period of time vary in amount and length of time given according to the term of service . Giving full pay would tend to encourage malingering and place a premium on sickness. Longer benefit periods protect the more serious cases, and so, the benefit period is often extended at one half the previous rate. There are often limitations such as ailments known to the employee before employment. Occupational disabilities are covered by workmen's compensation laws. Some companies offer complete medical service as well as cash benefits, the cost to the company of a plan of

this kind being between one to two percent of the payroll.

b. Joint Employer-Employee Plans

Under Joint Employer-Employee plans, the employee usually contributes one half or more of the funds and shares in the administration. There is often a limitation to employees receiving under a certain pay but the greater the coverage the more completely the element of adverse selection is avoided. In some plans membership is compulsory and in others examinations are required. The management is cooperative, the employees receiving varying proportions of representation depending on the plan. Dues which are collected by payroll deduction are in some cases a percentage of the wages, in others an arbitrary amount for each income group, and in others the same for all members. Benefits take these same three forms. The percentage basis is often more beneficial to the employee. Occasionally medical service is also offered.

c. Employee Plans

Plans sponsored entirely by employees who are usually joined in Mutual Benefit Associations are similar to the above plans except that the employer does not contribute money or management, although he frequently does make payroll deductions.

d. General Problems of Cash Benefit Plans

It would be difficult to state categorically which type of plan is the best as there are points favoring each one. The non-contributory plan assures the wage earner of

wages while he is sick, has a more centralized and therefore more efficient management, eliminates pressure by dominant groups for special favors, and eliminates the necessity of keeping everyone satisfied and giving some benefits to many rather than adequate benefits to the deserving. Under an employer-employee plan the employee may appreciate the fund to which he has contributed and try to safeguard it. Both recognize industry's responsibility to do something about the economic costs of sickness. The number of non-contributory plans is limited and the number of employee plans is not great. There is usually need for employer aid either in the form of contributions or help in selling the plan, in developing schedules of contribution and benefits, in investment of funds, and in collecting dues by payroll deduction. It is to the advantage of the employer to cooperate to the fullest extent and improve labor relations as the plans help the individual and the concern. As might well be expected, there are many problems to be met in initiating a cash benefit plan. Whether or not there is to be a restricted coverage with age, income, employment, and health limitations and who is to manage the plan must be determined. The charges are difficult to determine as costs must be estimated in advance. The rate of cash benefits is another difficult problem. Whether to offer a service plan, a hospital care plan, or physician's services or a combination thereof must be decided as must regulations, waiting periods, benefit periods, the distinction between permanent and temporary disability and general and

occupational incapacity, etc. Consequently it is not to be expected that there will be no mistakes. The possibility of the government's instituting a plan which would impose restrictions on industries should not be overlooked by an industrial organization in considering the advisability of starting a medical insurance plan.

2. Medical Service Plans

a. General Problems of Medical Service Plans

What has been said about cash benefit plans likewise applies to medical service plans except that in the latter case, there are many more problems such as deciding what type and how much care shall be made available to whom, what methods of financing and administering shall be employed, what relations shall be maintained with physicians, etc. As in the case of cash benefit plans, there are non-contributory, joint employer-employee, and employee medical service plans.

b. Administration

The problem of administration of medical service plans is more complex than that under cash benefit plans because the physicians must be considered. The latter rightly demand complete control over technical and medical matters. In organizing a professional staff the desirability of having full or part time general practitioners or specialists must be determined as must the method of payment of these doctors, by salary, fee for service, or per capita charge. The ratio of physicians, dentists, nurses, etc. to the number of people served is another consideration.

c. Financial Arrangements and Eligibility

The problems of financing and of eligibility are similar to those under cash benefit plans. The plan can be financed by the employer, the employee or both and the eligibility depends to a large extent on the ability to distribute risks. In some cases pre-employment examinations are had and eligibility is influenced by the results thereof.

d. Scope of Service

The scope of service can vary widely and include one, several, or all of the following: general practitioner and specialist service; home care; hospital care; preventive service; diagnostic service; physical therapy; appliances and drugs; dental service; provision for tuberculosis, venereal diseases, and mental illnesses; etc.

e. Quality of Service

The quality of the services offered by physicians must also be considered and depends largely on the competence of the physicians and the adequacy of material facilities, etc. Preventive services might include prenatal care, vaccinations, immunizations, examinations, and dental hygiene. Large companies can afford to have extended medical services and small companies can combine to achieve the same result.

In the following chapters, several industrial plans of the various types of sponsorship will be discussed and then compared. An analysis of the types of plans with specific attention to their advantages and disadvantages should provide valuable material for groups initiating plans or contemplating

revision or reorganization of plans. Objective studies of individual plans should establish a valid basis of evaluating them. Chapters VI,(1) VII,(2) and VIII(3) will be devoted respectively to a discussion of non-contributory, joint employer-employee and employee plans and Chapter IX(4) to comparisons, summaries, and conclusions. It should be emphasized that, as Gerhard Hirshfield said:

> "Any proposed health insurance system should be given the most careful study in all its relevant aspects so that the whole picture and the full scope will be clear to all before reaching a decision."(5)

---

(1) See Page 184
(2) See Page 206
(3) See Page 232
(4) See Page 257
(5) Hirshfield, Gerhard, "Social Security, Past, Present, and Future", American Taxpayers Association, Washington, D. C., 1944, Page 36

CHAPTER VI

NON-CONTRIBUTORY PLANS

Non-contributory plans are perhaps less numerous than joint or employee plans but not necessarily better. Recently the National War Labor Board ruled that free hospitalization insurance for workers is not a violation of wage ceilings and hence non contributory plans are being used more and more as a device to keep restless employees from quitting their jobs. A regular union contract to expire May 31, 1946 was made in early 1945 between the Hotel Association of New York and the New York Hotel Trades Council. It included a provision that the hotels would bear the entire cost of insuring union employees against sickness, accidents, and death, and that the union representatives would administer the fund.(1) Among participating hotels are the Commodore, New Yorker, Pennsylvania, McAlpin, and Vanderbilt.(2) This is but one example of what might be a precedent for the future. It might be well to consider in more detail a few non-contributory plans such as the cash benefit plans of the New England Tèlephone and Telegraph Company, and the Boston Edison Company, and the Medical Service Plans of the Endicott-Johnson Company, American Tobacco Company, American Cast Iron Pipe Company, and the Paraffin Company, and to determine what these plans have to offer.

(1) Business Week, "Workers Insured", Volume 813, Number 13, March 31, 1945, Page 106
(2) Ibid, Page 106

A. Non-Contributory Cash Benefit Plan-- The New England Telephone and Telegraph Company

1. Eligibility, Administration, and Financial Arrangements

All the employees of the New England Telephone and Telegraph Company who have served two years are eligible for benefits offered under this plan which is administered by a committee of five men appointed by the Board of Directors to serve during its pleasure.(1) This administrative committee determines conclusively all questions arising in the administration of the plan and is empowered to authorize disbursements, adopt necessary rules, employ assistants, etc. The expenses of the plan are entirely borne by the company.

2. Cash Benefits

Benefits begin on the eighth calendar day of absence on account of sickness,(2) and are as shown in Table 23 on Page 186. Successive disability periods are counted as one period in computing the time during which the employee shall be entitled to benefits except that any sickness occurring after an employee has been continuously engaged in the performance of duty for thirteen weeks shall be considered as a new sickness. An employee absent from duty on account of sickness must notify his immediate supervisor and is not entitled to benefits for time previous to such notice unless the

---

(1) New England Telephone and Telegraph Company, "Plan for Employees' Pensions, Disability Benefits and Death Benefits", Page 5

(2) Ibid, Page 5

TABLE 23

New England Telephone and Telegraph Company--Cash Benefits for Sickness and Accident

Disability	Years of Employment	Weeks of Full Pay (100% Loss of Earning Capacity for Partial Disability)	Weeks of Half Pay (50% Loss of Earning Capacity for Partial Disability)	Maximum Benefits
Sickness	2-5	4	9	
	5-10	13	13	
	10-15	13	39	
	15-20	26	26	
	20-25	39	13	
	25 --	52	--	
Accident--Total Disability	-- --	13	Remainder of Disability	$20 per week 6 years
Accident--Partial Disability	-- --	13	Remainder of Disability	$20 per week 6 years

Source - New England Telephone and Telegraph Company, "Plan for Employees' Pensions, Disability Benefits and Death Benefits", Page 36

delay was unavoidable. All claims for disability benefits must be made within sixty days from the first day of absence and in order to leave home during disability, written approval must be obtained from the committee or no benefits will be paid during such an absence. A disabled employee must submit to examinations to be entitled to benefits which will be discontinued if employees refuse to follow the recommendations of the committee.(1) The benefits are usually paid at the same time as the wages would be paid unless the committee decides in the case of a serious illness to make full settlement in a lump

---

(1) The New England Telephone and Telegraph Company, op. cit., Page 18

payment to enable the employee to pay bills. Accrued benefits, unpaid at the time of the death of the employee may be paid to his heir. After the maximum sickness disability benefits have been received, the employee must perform his duties for thirteen weeks before becoming eligible again.(1)

As can be seen there are a lot of restrictions applicable to this plan but nevertheless, the employee receives at no expense to himself partial or complete wages during all or part of his absence from work.

3. Limited Medical Program

Along with this cash benefit plan, the company has a limited medical program. When the employee applies for a job he is examined and classified as to physical condition and ability to do the type of work for which he is applying. Those in classes A and B are allowed to go to work although the latter must have a follow up appointment for purposes of examination, diagnosis and referral.(2) Examinations include physical, neurological, lab, and X-ray work. The company has a Tuberculosis clinic and an orthopedic clinic, a skin clinic and a gynocology clinic in which the employees can be treated for minor conditions. There is also an eye, ear, nose, and throat consultant who treats asthma, hay fever, etc. When absent from work employees receive wages as described

---

(1) The New England Telephone and Telegraph Company, op. cit., Page 19
(2) Lynch, Dr. Danial, Medical Director of the New England Telephone and Telegraph Company--Interview

above but no medical care. Eighty-seven per cent of the employees have payroll deductions for Blue Cross also.(1) The many forms used by the company in connection with the medical plan are shown in Appendix II starting on Page 295.

4. Miscellaneous Features

The first seven days of an illness are paid for by the employees' department and no evidence is required. Lay visitors call at the homes of the sick and tell them how to apply for benefits, etc.(2) Medical service is difficult to provide because the employees are widely scattered but nevertheless would be desirable. According to Dr. Lynch, the benefit plan helped increase the feeling of security of the company's employees as did the establishment by the employees of a credit union from which those in need can borrow.(3) The New England Telephone and Telegraph Company cannot include in its cost of production the cost of medical service as manufacturing companies like the Endicott Johnson Shoe Company(4) can, because the Telephone Company's rates are regulated by state and federal authorities. Before returning to work an employee who has been absent seven days and is therefore eligible for the company plan, must report to the clinic for an examination. The Medical Department keeps in close touch with each case, there being a special fund in the hands of the committee which can be distributed to employees who cannot receive

(1) Lynch, op. cit.
(2) Ibid
(3) Ibid
(4) See Page 194

adequate medical care otherwise.(1) Thus the employee is reasonably well covered.

5. Conclusions

The two year waiting period prior to eligibility is rather severe and reduces the value of this phase of the program to ten points. The administration is good, there being no need for employees to be represented when they do not help finance the plan. (Twenty points) The financial arrangements are excellent for this same reason. (Twenty points) The amount of service is limited (Ten points) but the quality of that offered, excellent, (Twenty points) making the whole plan worth eighty points.

B. Non-Contributory Cash Benefit and Hospitalization and Surgical Benefit Plan--Boston Edison Company

1. Origin and Development--1940 study

The plan of the Boston Edison Company is similar to that of the New England Telephone and Telegraph Company but it adds a hospitalization and surgical benefit feature. A sick benefit plan was inaugurated by the Boston Edison Company in 1913 but was abused by the employees who felt that they were entitled to sickness benefits and that such benefits should apply as rapidly as they accrued. It began to appear that the less the sickness benefit payments, the less the amount of sickness.(2) Consequently a study was made in

---

(1) Lynch, op. cit.
(2) Moses, Herbert W., "Benefit Plan Changed", Edison News, Volume 1, Number 1, July, 1940, Page 5

1940 and the following conclusions were made: The old plan was unusable because of its liberal terms and increasing costs; the average number of days lost per year per employee over a period of twenty-five years because of sickness was nine; three per cent of the employees are absent daily because of illness; certain employees use up their sickness allowance year in and year out; common cold causes two and three tenths days lost time per employee per year; time lost due to sickness is eighteen times that due to industrial accidents; periodic examinations if followed up are beneficial; women are worse sickness risks than men; and married women are worse risks than single women.(1)

2. New Cash Benefit Plan

On the basis of this study and past experience, a new plan was drawn up and put into operation in 1940. This plan is administered by a disablement committee who may suspend or extend benefits for just reasons. New employees are entitled to no benefits before the completion of twelve months of continuous active service. Reducing the departmental sick allowance from ten to five days means that employees can now receive only five days pay per year from their department before going on the company sick payroll instead of ten days to which they were formerly entitled.(2) Disablement benefits begin on the eighth day of continuous illness instead of the

---

(1) Moses, op. cit., Page 5
(2) Ibid, Page 5

fifteenth and are payable for a period which depends on the amount of service, the maximum being one year. Full pay is allowed during the initial disability period and three quarters pay during the secondary disability period as described below.

> "One week for each year of continuous active service completed by the employee on the December 31 prior to the inception of disability to a maximum of thirteen weeks defines the period of time during which full benefits are allowed. Three weeks for each year of continuous active service completed by the employee on the December 31 prior to the inception of disability to a maximum of thirty-nine weeks defines the period of time during which three quarter benefits are allowed."(1)

3. Hospital and Surgical Benefit Plan

As can be seen these benefits are less than those of the New England Telephone and Telegraph Company described above. However, this is compensated for, because, besides providing cash benefits for its sick employees the company also has a Hospital and Surgical Benefit Plan under which all full time employees who have had at least six months service with the company are eligible.(2) This plan is underwritten by the John Hancock Mutual Life Insurance Company of Boston.(3)

If application is made within thirty days from the date of eligibility no medical examination is required. The company pays the full cost of this insurance on its employees and an individual certificate of insurance is given the employees. Hospital and surgical expense benefits are paid upon

---

(1) Moses, op. cit., Page 5
(2) Boston Edison Company, "A New Hospitalization and Surgical Benefit Plan", Page 2
(3) Ibid, Page 2

submission of an itemized bill from the hospital and surgeon. The plan is administered by the Industrial Relations Department and terminates with employment. Hospital benefits are payable upon approval of a qualified physician if the insured is confined eighteen consecutive hours. Benefits amount to five dollars a day for thirty-one days. (1) Hospital service fees for X-rays, laboratory service, anaesthetics and administration thereof, and operating room, up to twenty-five dollars are also paid. (2) No benefits for confinement due to pregnancy are payable. Surgical benefits include the fee charge for the operation if not more than stated in the schedule of surgical operations to a maximum of one hundred and fifty dollars for any one period of disability. (3)

4. Dependents Plan

Besides offering these two free plans, the company offers a plan to insure the employees' dependents against hospital or surgical expenses. Wives and children between the ages of three months and eighteen years are considered dependents. No examination is required if application is made within thirty-one days after eligibility. The cost to employees is seventy-five cents per month for one dependent and one dollar and fifty cents for two or more. (4) The benefits are the same as those for the employee and continue

---

(1) Boston Edison Company, op. cit., Page 7
(2) Ibid, Page 7
(3) Ibid, Page 8
(4) Ibid, Page 5

while premiums are paid until the dependent becomes insured independently, the wife is separated or divorced, the child attains the age of eighteen, or the employee's insurance is terminated.(1)

5. Company Medical Department

The company also has a medical department which examines employees when they enter employment and periodically thereafter. The medical director has a fund of three thousand dollars to use for diagnosis and further studies as X-rays.(2) No employee who has been absent from work fourteen or more days may return to work until he has had a new examination. There is also a clinic which is run on an out patient basis. The employee can assign his benefits to a hospital or surgeon. According to the medical director, this plan pays the company even if too much money is given the sick employee because otherwise employees would come in half sick and do a bad job.(3)

6. Conclusions

As can be seen this plan is quite good. Perhaps one fault in the eligibility is the one year waiting period. (Fifteen points) The subscriber is not represented although he pays for his dependents and so the administration is worth fifteen points. As the subscriber only pays for his dependents, financial arrangements are good. (Twenty points)

---

(1) Boston Edison Company, op. cit., Page 11
(2) Interview with Dr. Noel Monroe, Medical Director
(3) Ibid

The plan gives hospital and surgical benefits and money with which the patient can purchase medical care but does not provide the latter as such. (Fifteen points) The quality of care in the clinic is excellent (Twenty points) making the total for the plan eighty-five points.

C. Non-Contributory Medical Service Plan Endicott-Johnson Company

1. Origin and Development

The discussion of non-contributory plans would not be complete without considering a few medical service plans as well as cash benefit plans. The medical service plan of the Endicott-Johnson Company of Johnson City, Endicott, Binghampton, and Oswego, New York, is one of the outstanding examples of a non-contributory medical service plan in the United States. The Endicott-Johnson Corporation is in the business of tanning leather and manufacturing shoes and has factories in the four above named cities. In 1918, George Endicott decided to give complete medical service to his workers and their dependent family members in order to improve their living conditions and keep them out of debt, a great factor in unhappiness. No attempt was made to develop a model for other corporations but the corporation intended to give the workers complete medical care of high quality with reasonable freedom of choice of physicians and hospitalization, medicines, laboratory, and X-ray examinations.(1)

(1) Jones, Edward M., "Endicott Johnson Medical Plan", Journal of the American Medical Association, Volume 126, Number 6, October 7, 1944, Page 339

2. Eligibility and Coverage

Over a period of twenty-six years the number of eligible workers has averaged seventeen thousand and the number of dependents thirty-two thousand.(1) At first, all workers were included from the first day of their employment. However, abuse resulted and people would work for the company for a few days and then apply for medical care for pre-existing conditions, and so a six month probationary period was instituted.(2) In September, 1940, when the defense plan was accelerated a greater number of temporary workers were not eligible. After Pearl Harbor the corporation lost many of its physicians to the army and continued to exclude new workers. Gradually a few additional physicians were obtained and four thousand workers were lost to the army and war industries and so the patient load was reduced.(3) On January 1, 1944, the company returned to the policy of furnishing complete medical care to all workers and dependents if in the company's employ at least six months.(4) The company considers the term dependents as including husbands and wives of workers not otherwise gainfully employed, children regardless of age who are not married or employed (unless it is the mother who is an Endicott-Johnson employee and the father works elsewhere in which case the children would not be covered), and parents of workers if dependent on the worker

(1) Jones, op. cit., Page 339
(2) Ibid, Page 339
(3) Ibid, Page 339
(4) Ibid, Page 339

and living with the worker for a considerable period of time. Each case is considered individually by the relief department if responsibility is divided between the worker and another. Individuals employed in the retail store or sales division may also receive medical care.(1)

3. Financial Management

Whereas the average cost to the company per worker per year is forty-eight dollars, the average cost per eligible person including dependents in 1943 was only twenty-one dollars.(2) There is also a voluntary sick relief society to which the employee may contribute twenty-five cents per week and in case of sickness for more than one week may draw twelve dollars a week for ten weeks.(3) The company frequently supplements these payments and extends their duration.

4. Scope of Service

There are three medical centers, one in Binghampton, one in Endicott, and one in Johnson. Workers in Oswego are cared for by part time physicians and referred to Endicott or Johnson for treatment. In each medical center there are from four to seven general practitioners with scheduled office hours of from two to three hours each day, at least one being in the office from eight A. M. to six P. M.(4) These doctors make calls at the workers' homes and follow the patient to the hospital. Each center has an internist, a surgeon, an

---

(1) Jones, op. cit., Page 340
(2) Ibid, Page 341
(3) Ibid, Page 341
(4) Ibid, Page 340

obstetrician, a pediatrician, an opthalmologist, and an otolaryngologist, all of whom have regular office hours and see patients referred to them by the general practitioners; and also part time endocrinologists, dermitologists, and thoracic surgeons.(1) Deliveries are cared for in the hospital and antepartum and postpartum care and baby clinics are provided. One syphilologist divides his time between the three centers, cares for venereal diseases, and performs cystoscopic and genitourinary procedures. There are also approved laboratories and a dental department of six dentists and four dental hygienists in each center.(2)

If a worker phones a center for a doctor, a clerk checks the file and if his name is listed, asks which physician is wanted and lists the call in a book. If the physician is busy the worker may ask for another or leave an open call, there being a physician on call at each center from six P. M. to seven A. M.(3) The patient may come to the office when his physician has office hours. Specialists spend their mornings seeing patients in hospitals and homes and their afternoons in office consultations. On Sundays and holidays, there is a physician on duty in each center and one man of each specialty on call, but the work is limited to emergencies. There is a complete pharmacy in each center and no routine procedures, each physician being allowed to treat the patient as he deems proper.(4)

(1) Jones, op. cit., Page 340
(2) Ibid, Page 340
(3) Ibid, Page 340
(4) Ibid, Page 340

In cases needing specialist care beyond the facilities of the center, the patients are sent to medical centers in New York City, Boston, Baltimore, Philadelphia, etc. or wherever necessary to obtain essential service, all expenses being paid by the corporation.(1) Most hospitalized patients go to the C. S. Wilson Memorial Hospital in Johnson City which is owned by the corporation, although occasionally the Ideal Hospital, a village one in Endicott, is used. The company pays the usual hospital rates according to the type of accomodation the physician decides is necessary, but the patient may get a more elaborate accomodation if he pays the difference. The heads of the medical and surgical departments rule on the necessity for special nursing service.(2)

5. Conclusion

Thus, Endicott-Johnson workers and their dependents receive at no cost to themselves complete medical service without any limitations; the patient-physician relationship is kept; and access is had to specialists, unlimited hospitalization, and unlimited amounts of laboratory and X-ray and other examinations. The entire service is free to the worker and the company assumes the whole expense as an operating cost. On the basis of these facts this plan could receive no rating except one hundred. Although the Endicott-Johnson plan is one of the best non-contributory medical service plans,

(1) Jones, op. cit., Page 341
(2) Ibid, Page 341

it is by no means the only one. That of the American Tobacco Company is interesting because the same plan is operating in the company's plants in several different cities.

D. Non-Contributory--Medical Service Plan American Tobacco Company and American Suppliers Inc.

1. Location

The American Tobacco Company has its central offices in New York City and has medical insurance plans in operation in Louisville, Kentucky; Reidsville, North Carolina; Durham, North Carolina; Philadelphia, Pennsylvania; and in Richmond, Virginia.

2. Eligibility and Coverage

In all of these five areas all employees are eligible and covered if they pass a physical examination, and there are no age nor income restrictions. In Louisville, there are nine hundred and seventeen employees covered.(1) In Reidsville, two thousand five hundred and seventy-four,(2) in Durham, two thousand six hundred and four,(3) in Philadelphia, one thousand and fifty,(4) and in Richmond, four thousand six hundred.(5)

3. Administration and Financial Arrangements

As the company pays the complete cost and the employee is charged nothing, it is only natural that the company is in charge of the administration.

---

(1) Klem, op. cit., Page 39
(2) Ibid, Page 72
(3) Ibid, Page 70
(4) Ibid, Page 83
(5) Ibid, Page 92

4. Scope of Service

In all these five areas the medical service includes that of a general practitioner in office clinic, home, and hospital; specialist service; surgery; and hospitalization in wards, the length of stay being at the physician's discretion, and maternity care being excluded.(1)

5. Quality of Service

The quality of service offered by the medical department of the American Tobacco Company and American Suppliers Inc. is good. In each of the Louisville, Durham, and Reidsville areas, there is one full time physician and two registered graduate nurses on the staff,(2) in the Philadelphia area there is only one part time physician and one full time registered graduate nurse;(3) and in Richmond there are three full time physicians and five registered graduate nurses.(4) These staffs are sufficiently large to give good care to all the patients.

6. Conclusions

The American Tobacco Company was chosen as an example of non contributory medical service plans because it exemplifies the situation in many large companies which have branches in several cities. Although the several medical insurance plans

(1) Klem, op. cit., Pages 39, 70, 72, 83, 92
(2) Ibid, Pages 39, 70, 72
(3) Ibid, Page 83
(4) Ibid, Page 93

used by the General Electric Company are different from one another, those of the American Tobacco Company are all alike. The eligibility feature includes all employees and hence is worth twenty points as are the financial arrangements which are handled entirely by the company which therefore has a right to administer the plan by itself. (Twenty points) The service is complete (Twenty points) and of good quality (Twenty points) and hence the plan is worth one hundred points.

E. Non-Contributory Medical Service Plan--American Cast Iron Pipe Company

1. Origin and Development

It must not be thought that the Endicott-Johnson Company and the American Tobacco Company are the only companies which offer good and complete medical service to their employees for nothing. The American Cast Iron Pipe Company of Birmingham, Alabama, also has a non-contributory service plan which has been operating for over thirty years. For the first ten years there was just one doctor with an office in the plant who took care of minor accidents and emergencies.(1) In 1923 the plan was reorganized and now provides for every health hazard of the employees and their dependents.

2. Eligibility and Coverage, Administration and Financial Arrangements

There is a clinic equipped with modern facilities and complete medical service is offered free to all the two

---

(1) Bray, C. B., "An Industrial Medical Care Plan", Medical Care, Volume 1, Number 3, Autumn, 1941, Page 341

thousand employees, one half of whom are colored, and their six thousand dependents at a cost to the company of seven hundred and twenty-five thousand dollars per year.(1) The directors are responsible to the management.

3. Scope of Service

Full and part time general practitioners, three dentists, specialists, and eight graduate nurses serve the patients(2) and offer among other things surgery; internal medicine; dermatology; eye, ear, nose, and throat care; pediatrics; orthopedics; dental care; hospital care in private hospitals in Birmingham, to which the company pays full rates for ward service; maternity and visiting nurse service; semi-weekly well-baby clinics, where mothers are taught to care for their children properly; immunizations and preventive service; prenatal and postpartum care; cold vaccines; examinations, etc.(3) Cash disability of eight dollars beginning the first week for non industrial accidents and the second for illnesses are also offered for thirteen weeks.(4)

4. Conclusion

The loss of man days because of illness in 1940 in this company was eight tenths of one per cent as compared to the national average of two per cent.(5) The company feels

(1) Klem, op. cit., Page 1
(2) Ibid, Page 1
(3) Bray, op. cit., Page 345
(4) Klem, op. cit., Page 1
(5) Bray, op. cit., Page 348

that the working efficiency of the employees has increased in terms of units of production so that money is saved by operating the plan. The plan of the American Cast Iron Pipe Company is worth one hundred points because it offers complete medical care to all employees at no cost to the individual.

It should not be inferred that, because the last three plans discussed were all rated one hundred, non-contributory plans are necessarily better than any other type of plan. As a matter of fact, an employee plan (the Stanocola Plan),(1) an employer-employee plan (the Henry J. Kaiser Plan),(2) and a city government plan (the New York City Plan),(3) were all rated one hundred.(4) The Endicott-Johnson Company, the American Cast Iron Pipe Company,(5) and the American Tobacco Company(6) plans deserve one hundred points each because they offer complete and free medical service to all employees. There are relatively few non-contributory medical service plans in the United States. Chief among these besides those discussed in this chapter are as follows: Yale and Towne Manufacturing Company, Stamford, Connecticut; Standard Wholesale Phosphate and Acid Works Inc., Baltimore, Maryland; New York Stock Exchange, New York; Jack and Heinz Inc.,

(1) See Page 246
(2) See Page 221
(3) See Page 44
(4) See Page 194
(5) See Page 201
(6) See Page 199

Bedford, Ohio; and John Wanamaker Company Inc., Philadelphia, Pennsylvania;(1) All of these companies happen to offer fairly complete medical service and would probably be rated one hundred under the system used in this thesis. However, as mentioned above, this does not indicate that non-contributory plans are better than other types nor that all non-contributory plans are worth one hundred points. The plan of the Paraffine Company Inc. discussed below exemplifies this point.

F. Non-Contributory Medical Service Plan--The Paraffine Company Inc.

1. Eligibility and Coverage

All Paraffine Company Inc. employees are eligible for enrollment in the non-contributory medical service plan of the Paraffine Company of San Francisco, California, and all twenty-four hundred employees are covered.(2) There are no age nor income restrictions but a physical examination is required for employment.

2. Administration and Financial Arrangements

As indicated above, the company pays the complete cost and administers the plan.

3. Scope of Service

Unlike the plans described above, only general practitioner care is provided at no cost to the employee, not

(1) Klem, op. cit., Pages 28, 41, 67, 73, 83
(2) Ibid, Page 20

complete medical and surgical care and hospitalization.

4. Quality of Service

The quality of service is good, there being one full time and one part time physician, one part time dentist, and three registered graduate nurses.(1)

5. Conclusion

The eligibility and coverage, administration, financial arrangements, and the quality of service each deserve twenty points but the scope of service is worth only ten points because it is so limited, making a total for the plan of ninety points.

That this plan is rated ninety instead of one hundred is an indication that, although certain general characteristics become apparent in plans of similar types, each plan must be studied individually. This point is further exemplified by the discussion of joint employer-employee plans in the next chapter.

---

(1) Klem, op. cit., Page 204

CHAPTER VII

JOINT EMPLOYER-EMPLOYEE PLANS

Joint-Employer-Employee Plans are perhaps the most numerous classification of plans. The Batchelder and Snyder Company and General Electric Company Plans are examples of typical joint cash benefit plans, and the plans of the Tennessee Coal, Iron, and Railroad Company, the Tennessee Valley Authority, and the Kaiser Shipyards exemplify Joint Medical Service Plans, the latter being particularly good. Insurance company plans are in a sense joint employer-employee plans in that frequently both employer and employee contribute. In fact, four hundred companies now insure forty million citizens against accidents and ill health.(1) However, insurance company plans have been discussed in Chapter IV.(2) The various joint employer-employee plans in Binghampton, New York, have been described briefly and included in this chapter to indicate what can be done in one area and that of the Consolidated Edison Company to illustrate a plan offering the doctor complete freedom.

A. Joint Employer-Employee Cash Benefit Plan--Batchelder and Snyder Company Inc.

1. Eligibility and Administration

The Batchelder and Snyder Company Incorporated's

---

(1) Walker, C. Lester, "Shield Against Health Hazards", Nation's Business, Volume 33, Number 2, February, 1945, Page 34
(2) See Page 148

medical insurance plan is administered by the company in conjunction with the Connecticut General Life Insurance Company and all employees are eligible. The company has assumed a substantial part of the premiums and all the administrative costs. The insurance becomes effective as soon as the policy is taken out and if the employee leaves the company he may exchange the insurance for an individual policy. (1)

2. Financial Arrangements and Cash Benefits

Under the accident and sickness benefit policy, weekly benefits will be paid beginning the fourth day of disability and continue for a maximum of thirteen weeks for any one disability. (2) Unlike the non-contributory plans of the New England Telephone and Telegraph Company and the Boston Edison Company, (3) there is no limit to the number of times during the year that an employee may receive accident or sickness benefits, except that no employee over sixty may receive benefits during any twelve consecutive months for more than thirteen weeks. (4) The amount of benefits and costs are indicated in Table 24 on Page 208.

For each day in the hospital the insured will be paid five dollars, up to a maximum of thirty-one days during any one period of disability. The number of confinements during any year is not limited. (5) For pregnancy, childbirth or

---

(1) Batchelder and Snyder Company Inc., "Employees Group Insurance Plan", Page 4
(2) Ibid, Page 4
(3) See Pages 185, 189
(4) Batchelder and Snyder Company Inc., op. cit., Page 4
(5) Ibid, Page 4

TABLE 24

Batchelder and Snyder Company Inc.--Benefits and Costs

Weekly Salary	Accident and Sickness Weekly Benefit	Cost With No Dependents, Weekly	Cost With One Dependent	Cost With Two or More Dependents
Under $19	$10.50	$.35	$.50	$.60
$19-$25	$14.00	$.40	$.55	$.65
$25-$35	$17.50	$.45	$.60	$.70
$35-$47.50	$24.50	$.55	$.70	$.80
$47.50 and Over	$35.00	$.70	$.85	$.95

Source - Batchelder and Snyder Company Inc. "Employees Group Insurance Plan", Page 3 and 4

miscarriage cases, benefit is payable up to fourteen days; and for hospital fees, reimbursement will be made up to twenty-five dollars, the maximum reimbursement for surgical operation in one period being one hundred and fifty dollars.(1)

Benefits for families are also on a reimbursement basis and will cover hospital charges for bed and board up to three dollars per day for thirty-one days, and fees of fifteen dollars.(2) The reimbursement for maternity benefits is three dollars per day for ten days after a nine month waiting period. Surgical fees for family members are not included.(3)

3. Conclusions

This plan should receive twenty points for eligibility but only fifteen points for administration as the subscriber

(1) Batchelder and Snyder, op. cit,, Page 5
(2) Ibid, Page 6
(3) Ibid, Page 6

has no say. The charges are high for service rendered (fifteen points) and the service far from complete, only cash benefits for medical ailments being provided. (ten points) The quality of the service is up to the individual's choice as reimbursement is used. (twenty points) The plan therefore is worth eighty points.

The plans of the General Electric Company are similar in nature to this plan and hence worthy of mention in order to indicate that plans of the various companies although not identical with those of other companies with the same general type of plan may often be similar.

B. Joint Employer-Employee Cash Benefit Plan General Electric Company

1. Boston Office Plan

Different plans are in operation in different branches of the General Electric Company. The Boston office had been insuring with the Blue Cross for the past eight years when seventy-five per cent of its employees voted to retain this plan instead of adopting the new company plan.(1) The premiums have to be collected individually because the company will not permit a payroll deduction for any plan other than its own.

2. Company Group Sickness, Accident, and Hospital Expense Benefit Plan

---

(1) Interview with Mr. F. Beacher, Manager of the Boston Office of General Electric.

The company offers two plans, a Group Sickness, Accident, and Hospital Expense Benefit Plan and a Dependents Hospital Expense Benefit Plan. Under the former, the Company administers the plan, and employees are eligible only after one year of service, contributions being based on earnings, ranging from One dollar and fifteen cents to One dollar and seventy cents per month, and being collected by payroll deduction. (1) Benefits for sickness or accident are eleven dollars to fifteen dollars and fifty cents per week, and daily hospital expense benefits after eighteen hours in the hospital amount to three dollars and fifty cents to four dollars and seventy-five cents per day for room and twenty three dollars and seventy-five cents per sickness for special service. (2) The insurance is payable on the eighth day for thirteen weeks, six weeks for pregnancy. Employees over sixty are only entitled to one thirteen week period of sickness a year. If there is any surplus at the end of the year it is returned to the employees in the form of suspended premiums as in 1943 when two months premiums were suspended. (3) The General Electric Company has a contract with the Metropolitan Life Insurance Company whereby the former agrees to pay a certain amount per year to the insurance company to cover a certain number of employees, and General Electric sets its own rates and collects the premiums, paying the balance if any to the insurance company. (4)

(1) Interview with Mr. F. Beacher
(2) Ibid
(3) Ibid
(4) Ibid

3. Dependents Hospital Expense Benefit Plan

The Dependents Hospital Expense Benefit Plan covers wives and unmarried children between the ages of three months and eighteen years, of employees who have paid the required premium. The premium is based on earnings, amounts to sixty-seven to ninety cents per month, and entitles the dependents to daily hospital benefits of three dollars and maximum hospital special service of twenty dollars. (1) No benefits are payable because of pregnancy. This plan is offered to dependents without examination if applied for within thirty-one days after the year waiting period is over.

As can be seen, this plan is similar in many respects to that of the Batchelder and Snyder Company, (2) differing only in amount of payments and benefits. Hence it is worth the same rating, eighty points. A discussion of the Lynn Riverworks of General Electric, which has an employee plan, may be found in Chapter VIII. (3)

C. Joint Employer-Employee Medical Service
Plans--Binghampton, New York

1. Dunn and McCarthy Shoe Factory

Industrial medicine is probably more widely practiced in Binghampton, New York, than in any other part of the country and hence the situation there is worth noting. In 1913, a Mutual Benefit Association was organized at the Dunn and McCarthy Shoe Factory by the employees to provide sickness and

(1) Interview with Mr. F. Beacher
(2) See Page 206
(3) See Page 237

death benefits.(1) Later a registered nurse was hired and a complete well equipped first aid room was established. In 1916 a daily clinic was established, home visitations by an employed doctor were offered, and the company began to contribute one third of the cost of running the plan, thus making it a joint employer-employee plan. By 1923, the plan had expanded to include complete coverage of medical, hospital, and dental needs of employees and in 1928, operations were offered dependents who needed them. Members were divided into classes according to weekly earnings in paying for and drawing sick benefits, dues being fifteen, twenty, and twenty-five cents according to the employee's income.(2) Any employee can join and receive medical benefits including specialist services after he has paid dues for two months and may receive hospitalization and operation benefits after six months. However, no member can draw sick benefits in any one year for more than ten weeks or three hundred and fifty dollars.(3) The workers can choose their own surgeons, specialists, and dentists. This plan deserves only fifteen points for eligibility because of the required waiting period, twenty points for administration which is controlled by a mutual benefit society, twenty points each for the financial arrangements and the quality of care, and fifteen points for the scope of service which is limited, making a total of ninety for the plan. The Dunn and McCarthy Shoe Factory Plan has served as the basis of several other plans in the same area in other industries.

---

(1) Bloom, M. C., "Variations in Current Industrial Medical Service Plans", Journal of the American Medical Association, Volume 126, Number 6, October 7, 1944, Page 335
(2) Ibid, Page 335
(3) Ibid, Page 336

2. Spaulding Bakeries

In 1930 a similar mutual benefit association was organized at the Spaulding Bakeries in Binghampton in which the member can choose his physician. (1) Dependents under sixteen are included, the weekly charge, part of which is paid by the company, being from twenty to forty-five cents. (2) The doctor has a stake in the success of this plan and it is working out well.

3. Ansco Corporation

In 1929, the Ansco Corporation organized a plan on the contract basis, and in 1933 instituted a free choice plan to which the company contributed fifty per cent of the cost and the employees paid one dollar and twenty-five cents. This plan was extended in 1944 to include care for dependents at a slight additional cost. There is a three months waiting period under this plan. (3)

4. The Binghampton Die and Machine Company

The Binghampton Die and Machine Company although it only has fifty employees operates a similar plan with a three month waiting period and charges of thirty cents a week. (4)

5. Conclusions

These plans have been mentioned briefly in order to show that the principle of freedom of choice can be applied successfully and adapted to every kind of industry and that this is superior to the contract or panel method in that it

---

(1) Bloom, Op. Cit., Page 337
(2) Klem, Op. Cit., Page 58
(3) Ibid Page 58
(4) Ibid Page 56

creates good will among the physicians, employers and employees.

D. Joint Employer-Employee Medical Service Plan
Consolidated Edison of New York

John J. Wittmer described the necessary voluntary health insurance plan as one which,

> "completely and comprehensively covers all phases of illness and health, a plan which has a budgetary basis that will insure an income, commensurate with the doctor's education qualifications, maintainance of social level, and vast expenditure of time and energy and yet not be so costly that it will be beyond the average subscriber's financial means; health insurance that includes the medical fraternity as administrators."(1)

This goal is not easy to attain but is possible. Many plans can be criticized because the physician does not have enough control. This condition is not apparent in the Binghampton Plans nor that of the Consolidated Edison Company of New York which has a medical plan in the form of a mutual aid society formed by the employees who pay five ninths of one per cent of their weekly salary (2) and receive after three months of employment cash benefits and total medical and basic dental service from four full time and fifty-one part time doctors, forty-five dentists, and twelve graduate nurses all of whom are paid on a fee for service basis. (3) The company contributes an equal amount to that given by the employees thus helping make this a joint plan, although the entire medical

---

(1) Wittmer, John J., "Variations in Current Industrial Medical Service Plans", Journal of the American Medical Association, Volume 126, Number 6, October 7, 1944 - Page 344

(2) Ibid, Page 343

(3) Klem, op.cit. Page 65

service is under the absolute authority of a medical director. Among the advantages of this plan is the fact that every employee in the middle and lower income brackets pays his way when he is ill. The average doctor's income is higher than in private practice and the doctors have money for research and preventive work. One trouble with this plan is that it does not include family members. This factor should reduce the weight of the eligibility feature to fifteen points. The financial arrangements, administration, and quality of service are all worth twenty points and the scope of service which does not include hospitalization, etc. is worth fifteen, making the whole plan worth ninety points. This plan will not be discussed any further but serves to illustrate that joint plans in which the doctors have complete control of the medical administration can exist and be successful.

E. Joint Employer-Employee Medical Service Plan

Tennessee Coal, Iron, and Railroad Company

1. Origin and Development, and Administration

A few joint employer-employee medical service plans should be discussed in more detail in order to give a complete picture of this type of plan. The Tennessee Coal, Iron, and Railroad Company's Medical Insurance Plan is typical of the joint employer-employee classification. This company is a subsidary of the United States Steel Corporation and operates plants in an area within fifteen miles of Birmingham, Alabama. In normal times it has about twenty-three hundred employees. (1)

---

(1) Tennessee Coal, Iron, and Railroad Company, "A Discription of its work and Activities", Birmingham, Alabama, Jan. 1938, Page 1

It was among the first industrial plants to set up a medical care plan, responsibility for the medical care of the workers having been assumed by the company since 1913. The company is in complete control of the administration of the plan although it has a joint feature in that more than one half the support comes from the employees.(1) The coverage and the reasonable fees indicate a real desire to cover persons most in need of assistance. The plan has brought medical resources to a community where otherwise none existed because of the nature of the population.

2. Eligibility and Coverage, and Financial Arrangements

Those employees with wages of less than two hundred and fifty dollars per month who live within two and one half miles of the dispensary are eligible to pay the full medical fee of one dollar and seventy-five cents per month and those not living within this distance and earning under two hundred and fifty dollars by paying one dollar and thirty cents per month can get the same services except that they get no home services.(2) Dependents are likewise eligible. Approximately thirty-three thousand subscribers, ninety per cent of employees, and twelve thousand dependents are covered.(3)

3. Scope of Service

The services offered include regular office hours held by doctors at each dispensary; medical treatment; minor surgery at home; in clinic, and in hospital; and treatment in

---

(1) Tennessee Coal, Iron, and Railroad Company, op. cit., Page 11
(2) Ibid, Page 2
(3) Klem, op. cit., Page 5

and admission to the employees' hospital at one dollar and twenty-five cents per day.(1)

There is also a special pediatric service which holds infant and preschool clinics weekly to check up on the general health of the employees' children, treat minor ailments, advise as to correct feeding, vaccinate, consult, examine, and report defects, hold classes instructing mothers before and after birth, etc.(2)

The Medical Division Employees' Hospital in Fairfield, Florida, has three hundred and ten beds, is completely equipped for treatment of all types of medical and surgical cases, has a full staff of physicians and surgeons, has daily clinics, etc.(3) An employee is eligible for admission when the company physician thinks it advisable and accomodation is available. There is a nominal charge for services by eye, ear, nose, throat, obstetric, asthma, and other specialists but no charge for consultations, examinations, and lab work in the outpatient department. There are also standard charges for private rooms, etc.(4) The dental clinic offers complete service at low rates and the sanitary division supervises environmental conditions which might influence health.(5) Non subscribers may receive medical treatment at any dispensary if they pay for it.(6)

(1) Klem, op. cit., Page 5
(2) Tennessee Coal, Iron, and Railroad Company, op. cit., Page 2
(3) Ibid, Page 2
(4) Ibid, Page 5
(5) Ibid, Page 5
(6) Ibid, Page 5

4. Quality of Care

The personnel and equipment are very adequate and include dispensaries in nine villages; emergency hospitals in five; five dental clinics; an employees' hospital; and forty-five district physicians , three resident physicians, and ten internes, on the hospital staff.(1) The physicians are all full time employees and are remunerated on a straight salary basis. The quality of service is excellent.

5. Conclusions

As can be seen, this plan is administered exclusively by the company and thus only worth ten points for this feature. The eligibility is satisfactory, all employees being allowed to join. (Twenty points) The financial arrangements are adequate in that the employer and employee share the expense. (Twenty points) Service is not complete for although hospital and specialist service are offered there is an extra charge for these features, making them worth only fifteen points. The quality of the medical service is excellent and worth twenty points, making a total for the plan of eighty-five. The Tennessee Valley Authority's Plan is similar to, though different than the above and so will be discussed next by way of comparison.

E. Joint Employer-Employee Medical Service Plan
Tennessee Valley Authority

1. Origin and Development

As the Tennessee Valley Authority has construction workers at isolated locations doing work where physical fitness is at a premium and risks of accident great, it has instituted

---

(1) Tennessee Coal, Iron, and Railroad Company, op. cit., Page 5

industrial Health Programs and Medical Care Plans, those at the Kentucky Dam Project being a typical example. The voluntary medical care program is for all employees residing in the construction village and provides all necessary routine medical service and additional services for payment of prescribed fees. The project has developed to such an extent that now it has consulting rooms, X-ray and clinical laboratories, an eighteen bed hospital, three physicians who receive salaries of three thousand two hundred dollars to four thousand two hundred dollars per year, six graduate nurses at one thousand nine hundred and eighty dollars to one thousand six hundred and twenty dollars, four orderlies at one thousand eighty dollars to one thousand two hundred and thirty dollars, a cook at one thousand two hundred and sixty dollars to one thousand four hundred and forty dollars, and an attendant at one thousand two hundred and sixty dollars to one thousand four hundred and forty dollars.(1)

2. Eligibility and Coverage

All Kentucky Dam Employees and their dependents in the area of the construction village and neighboring villages are considered in the full service area and those in adjacent territories as in the limited service areas. Home service is only offered in the former area and otherwise the service in the two is identical. A few non-employees who reside in the reservation are also eligible.(2)

3. Administration

A local board of control supervises the operation of the program, adjustment of complaints, development of detailed

(1) Bishop, Eugene L., "Medical Care at a T. V. A. Project", Medical Care, Volume 2, Number 3, July, 1942, Page 248
(2) Ibid, Page 248

policies, recommendations for extension of service, etc. There is a representative from each construction supervisory group, from the local resident employees', from the camp management, and from the personnel, health, and safety departments.(1)

4. Financial Arrangements

The fees for full service which are one dollar per month for single employees and two dollars for families are deducted from the employees' wages in advance.(2) Drugs, special supplies, and appliances not procurable locally are provided at cost plus ten per cent. For participants, the fee for use of the operating room is ten dollars if no hospitalization is required and seven dollars and fifty cents if the patient is hospitalized. There is no charge to participating employees for hospital rooms but dependents must pay one dollar and twenty-five cents a day.(3) Participating employees living in the full service area don't pay special fees for home service for themselves, and only fifty cents during the day and one dollar at night for dependents.(4)

5. Scope of Service

Services offered include: periodic physical examinations and consultations; office visits for medical conditions; minor surgery; office visits and dressings after surgical operations; office visits for prenatal examinations and treatment; venereal disease treatment; prenatal and well baby clinics;

(1) Bishop, Op. cit. Page 248
(2) Ibid Page 251
(3) Ibid Page 251
(4) Ibid Page 251

infirmary care for all general and surgical conditions, except tuberculosis, mental diseases, and prolonged chronic illnesses; nursing service; laboratory examinations; physicians service for general medical conditions and uncomplicated obstatrical cases; minor surgical services; and home calls in full service areas if the patient is physically unable to report to the medical center.(1) Office hours are from eight A. M. to five P. M. daily, but someone is always on duty at the medical unit.(2)

6. Conclusions

As for the extent of participation in the program, in 1941 one thousand one hundred and sixty-seven out of two thousand employees and their two thousand one hundred and twelve dependents were voluntary members of the prepayment plan.(3) This wide participation indicated that the employees appreciated the good medical service offered. Further figures on the utilization of the services of this project are shown on Table 25 on Page 222.

This plan is in many respects similar to that of the Tennessee Coal, Iron, and Railroad Company(4) except that under the T. V. A. Plan, the consumers join in the administration to a limited extent making this feature of the plan worth twenty points instead of ten. Thus this plan is worth ninety points.

G. Joint Employer-Employee Medical Service Plan

Henry J. Kaiser's Shipyards

1. Origin and Development

Perhaps the most famous and most effective joint

---

(1) Bishop, op. cit., Page 250
(2) Ibid, Page 250
(3) Ibid, Page 253
(4) See Page 215

TABLE 25

Services Performed Under Medical Care Program of the Kentucky Dam T. V. A. Project 1940-41 on 1380 Employees

Service	Number of Utilizations of Service
Visits to Physician for General Medical Services	3,003
Home Calls by Physicians	271
General Hospital Services	10,063
Laboratory Services--(Urinalyses, blood counts, X-rays, microscopic, examinations)	1,536
Major and Minor Surgery and Orthopedic Procedures	341
Typhoid, Smallpox, Diphtheria, and Other Immunizations	244
Infants and Preschool Children Examined at Well Baby Clinic	147
Women Given Prenatal and Postnatal Examinations	84
Venereal Disease Treatment	36
Obstetrical Cases Delivered	10

Source - Bishop, Eugene L., "Medical Care at a T. V. A. Project", Medical Care, Volume II, Number 2, July, 1942, Page 248

employer-employee medical service plan in existance today is that at the Henry J. Kaiser Shipyards. About ten years ago, Henry J. Kaiser started providing medical care with no preconceived idea or plan to his workers in areas where there was neither medical nor hospital care. He tried the fee for service idea and discarded it for it couldn't provide service which the workers could afford to purchase. His new plan had three basic principles: prepayment, group practice, and adequate facilities. Prepayment spreads the costs. Group practice is economical, stimulates the physician, insures ready accessibility of other physicians for consultations, utilizes younger doctors, increases the productivity of research, etc. (1) The worth of adequate facilities as doctors' offices, hospitals, laboratories, X-Rays, etc. under one roof is evident, as is the economy in saving of travel and duplication of equipment and personnel. What makes the Kaiser plan so good is that complete and expert medical care is given the Kaiser workers, at health centers personneled by doctors who are free from bureaucratic governmental control, at prices which individuals could not possibly offer, and under such conditions that the workers have a voice in the management, both financial and administrative.

2. Richmond California Shipyards

   a. Eligibility and Coverage, and Financial Arrangements

The Kaiser plan is in operation at the Richmond Shipyards in Richmond, California where all employees who have been

---

(1) Garfield, Sidney R., "Health Plan Principles in Kaiser Industries", The Journal of the American Medical Association, Volume 126, Number 6, October 7, 1944, Page 337

employed at least four weeks are eligible to subscribe to the plan at a weekly cost of fifty cents which is deducted from the pay roll.(1) In 1944 there were sixty-seven thousand subscribers, seventy-nine per cent of those eligible.(2)

b. Scope of Service

As a means of preventive protection, subscribers receive advice and treatment for all minor ailments and all necessary medicines, medical and surgical supplies, vaccinations, inoculations prescribed by the attending physician, and insulin.(3) Diagnostic services offered include basal metabolism, electrocardiagrams, laboratory examinations, urinalysis, blood counts and chemistries, dental X-rays, eye examinations, etc.(4) Complete medical and surgical care at hospital, at first aid stations, or at the subscriber's home is provided depending on the amount needed up to one year for any one injury or illness. Room and board in the hospital up to one hundred and eleven days for any one illness, private rooms and private nurses when prescribed by the physician, use of surgery, X-rays, laboratory, medicine, physiotherapy, and blood transfusions are also provided as is ambulance service within a radius of thirty miles and emergency treatment anywhere up to one hundred dollars.(5) Chronic illnesses for which a subscriber has had medical treatment within one year

---

(1) Kaiser, Henry J., "A Health Plan, Richmond Shipyards," Richmond, California
(2) Klem, op. cit., Page 14
(3) Kaiser, op. cit.
(4) Ibid
(5) Ibid

preceding his subscription date are not included except for emergency treatment thereof. Also excluded are dental services, epidemic diseases, artificial limbs, childbirth, pregnancy, glasses, glass eyes, and injuries resulting from acts of the public enemy.(1) The field hospital in Richmond and the Permanente Foundation Hospital in Oakland, California, are both under the direction of Dr. Sidney R. Garfield. Subscription may be terminated by the subscriber or doctor upon one week's notice in writing. It also terminates with the subscriber's employment. Upon termination the subscriber is entitled to hospital and medical services provided in the plan for the treatment of any illness or injury covered by the plan which arose prior to termination.(2)

3. Northern Permanente Foundation, Vancouver, Washington

A similar plan is in effect at the Northern Permanente Foundation in Vancouver, Washington. All employees are eligible to subscribe without exception at a cost of eighty cents per week for each adult member and fifty cents for each child.(3) There are thirty thousand five hundred dependents enrolled in this plan.(4) The cost is greater than under the Richmond Shipyards Plan because certain exclusions as treatment of contagious diseases, preexisting conditions, maternity care, etc. have been removed. Hospital services are available at the

---

(1) Kaiser, op. cit.
(2) Ibid
(3) Kaiser, Henry J., "Your Health Plan", Northern Permanente Foundation
(4) Klem, op. cit., Page 98

Northern Permanente Hospital. Family members as well as employees are entitled to complete medical care, the only exclusions being tuberculosis and mental diseases. In speaking of these plans, Henry J. Kaiser said:

> "The greatest favor that business can do for its employees is to provide a prepaid health plan that will guard the worker and his dependents against the tragedy of unpredictable and disastrous hospital and medical bills."(1)

He has done just that by instituting these plans.

4. Southern Permanente Foundation, Fontana, California

a. Eligibility and Coverage

There is also a Southern Permanente Foundation in Fontana, California, which was started September 11, 1943. All employees are eligible and there are no age, income, or examination restrictions. Persons not covered under the plan may be treated at the regular fees. After the first week of the plan's existance in 1943, there were twelve hundred subscribers and twelve hundred dependents, thirty per cent of those eligible.(2)

b. Financial Arrangements

Subscribers and dependents over sixteen pay sixty cents per week, those under sixteen paying thirty cents.(3)

c. Scope of Service

The services are offered for one year for any illness and include general practitioner service in clinic, home,

---

(1) Kaiser, op. cit.
(2) Klem, op. cit., Page 10
(3) Ibid, Page 10

and hospital; specialist service; surgery; dentistry; diagnosis; X-ray; maternity care for sixty dollars; and hospitalization for sixty days.(1)

d. Quality of Care

The quality of service is good there being six full time physicians and twenty registered graduate nurses.(2)

5. Family Plan

A special family health plan has been started for the employees of the Permanente Foundation Hospitals so that every Kaiser employee will be covered. The charge under this plan is seventy-five cents for a wife and fifty cents for each child. The services are similar to those of the other three plans.(3)

6. Conclusions

Dr. Sidney R. Garfield, Medical Director of the Kaiser Plans, has indicated that most of the mistakes made in administering this plan resulted from underestimation of the number of employee subscribers and overestimation of their physical condition. Nevertheless, under the Kaiser Plans, there has been performed one of the most comprehensive jobs of furnishing medical care in the country. Five hundred thousand dollars of the debt of seven hundred thousand dollars incurred in building and equipping the hospitals has been retired.(4)

(1) Klem, op. cit., Page 10
(2) Ibid, Page 10
(3) Garfield, Circular
(4) Garfield, Sidney R., "First Annual Report of the Permanente Foundation Hospital," Permanente Foundation Medical Bulletin, Volume II, Number 1, January, 1944, Page 37

Doctors have been paid five hundred thousand dollars, their salaries ranging from forty-eight hundred dollars to fourteen thousand dollars a year.(1) The members have been provided with comprehensive coverage despite the fact that they are below par physically. According to Dr. Garfield, relations with the medical profession have been poor because of lack of understanding of the motives, distrust of the financial plan, and fear of the resulting effects on the economy of private practice.(2) Actually these fears are ungrounded and health centers similar to those in the Kaiser Shipyards should be constructed at strategic areas throughout the country. Physicians could be given the choice of remaining in private practice, part time in private practice and part time in group medicine, or full time in group medicine. The older men with large practices would probably remain in private practice and the younger men go into full time group medicine. Competition would be between groups instead of individuals.

In conclusion, the Kaiser Plan is excellent. In regard to eligibility and coverage, no one is excluded. (Twenty points) The administration is liberal and the physician and the consumer are represented. (Twenty points) The financial arrangements are good and not too high. (Twenty points) for the extensive service offered by Northern Permanente Foundation

(1) Garfield, op. cit., Page 37
(2) Ibid, Page 37

(Twenty points) and the quality of the service is also excellent, making the plan worth one hundred points.

H. The Trend

The trend today seems to be toward joint employer-employee plans in which both the employer and the employee share in the administration. This can be exemplified by the case of the Southern Pacific Company Hospital Service for Employees which was established in 1868 and which switched from company control to a joint employer-employee board, seven of whose thirteen members are employees, on May 1, 1945 under orders from an arbitration panel appointed under the Federal Railway Act.(1) This change was caused by a petition on June 10, 1944 by fifteen rail unions representing eighty thousand Southern Pacific employees. The company now operates a large hospital in San Francisco and several smaller ones elsewhere. The employees won the decision on the strength of the argument that since they paid ninety-three per cent(2) of the maintanance costs of the plan, they should have a voice in its administration. The railroad besides surrendering control, also pays half the cost of treating employees injured on the job. In the past this cost was borne by hospital funds contributed by weekly payroll deductions. The issuing of annual financial statements and the opening of cost records to employees were also required. This change might constitute a precedent

---

(1) Business Week, "Management Shift", Volume 813, Number 13, March 3, 1945, Page 102
(2) Ibid, Page 102

to be followed by other groups of employees who contribute to the support of joint plans but do not have voice in their administration.

I. Conclusions

It can be seen from this discussion of joint employer-employee plans, both cash benefit and medical service, that much can be accomplished by this method. Its main advantage over the non-contributory and employee plans is that neither the employer nor the employee need bear the complete responsibility of administering nor the complete burden of financing. This freedom from responsibility is perhaps the reason why this type of plan seems to be more prevalent at the present time, but does not necessarily indicate that joint plans are superior. That this is so can be shown by the fact that the plans discussed in this chapter have received ratings from eighty points, the lowest given herein to industrial plans, to one hundred which the Kaiser Plans received. The non-contributory plan of the Endicott-Johnson Company (1), the employee plan of Standard Oil Company of Louisiana, (2) and others also are worth a rating of one hundred indicating again that there is no one best type of plan. It might be well to emphasize again that although the plans receiving one hundred are the best plans, the rating given to the various plans does

---

(1) See Page 194
(2) See Page 246

not indicate the plan's worth for every purpose. A plan receiving eighty points might be better for some purposes than one receiving eighty-five. However, by assigning different maximum weights to the five main features used in weighting these plans, the qualified expert can quickly evaluate the plans by utilizing the weights assigned herein. The one large classification of plans which may be used to solve the problem of "Medical Insurance in Industry" which has not yet been discussed is employee plans and hence the following chapter has been devoted to this topic, after which the various features and plans will be compared and contrasted and conclusions will be drawn.

CHAPTER VIII

EMPLOYEE PLANS

It should not be assumed that employee plans are any the less important because they have been left until the last in this discussion of the various means of solving the problem of "Medical Insurance in Industry." The plans of William Filene's Sons Company, the Lynn Riverworks of General Electric and the American Bosch Company are good examples of employee cash benefit plans run by mutual benefit associations. Employee medical service plans are not as numerous as joint employer-employee medical plans or employee cash benefit plans but nevertheless play an important part in the field. The Colonial Beacon Oil Company Plan is a typical employee medical service plan and the Stanocola Plan a particularly good one. After the discussion of these plans which follows, the various plans will be compared.

A. Employee Cash Benefit Plan

William Filene's Sons Company

1. Old Plan

a. Origin and Development

In 1900, Dr. George Crandon, A. E. Filene's physician, established at Filene's Department Store a clinic similar in scope to an outpatient clinic where employees could get advice and treatment for minor ailments.(1) Whether or not the patient

---

(1) Gargill, Dr. Samuel, Medical Director of the Filene's Clinic--Interview

had a private physician was constantly kept in mind and if the complaint was serious, the nurse would contact this doctor if any. If the patient had no particular private physician, he had the option of going to a recommended neighborhood physician, a hospital clinic, or any physician. The clinic is substantially the same today. Thirty years ago, the employees voluntarily formed a Mutual Benefit Society which was accepted by the store and carried by it until the society could finance itself. This involved the examination of each employee to determine the existance of organic or chronic disability. For this purpose the society hired a doctor.(1)

b. Eligibility and Coverage and Administration

According to the by-laws of the Filene's Employees' Benefit Society, every employee becomes a member six months after his entrance on the regular payroll and remains one as long as he is on the regular payroll.(2) The Board of Governors of this society consists of the president, vice-president, secretary, and treasurer, and four additional officers all of whom are elected by the members annually by ballot. The secretary receives all money for the society and pays it to the treasurer at least once a month, investigates all claims of disability, prepares an annual report of receipts and expenditures, and is bonded for $5000 at the expense of the society.(3)

---

(1) Gargill, op. cit.,
(2) William Filene's Sons Company, "By-Laws of the Filene Employees' Benefit Society", Page 6
(3) Ibid, Page 6

The treasurer keeps an account of the finances of the society and the other officers have the regular duties of comparable officers in any society. The Board of Governors has entire supervision of the society, its property and affairs, and may make final decisions on any disputed claims for disability. The board has monthly meetings, and the society has annual meetings.(1)

c. Financial Arrangements

Dues are four cents for every dollar of weekly salary with maximum dues of two dollars and forty cents per month on salaries of sixty or more per week and are payable even during periods of disability unless the latter are over twenty-six weeks in duration.(2) If the amount in the fund is not sufficient to pay the accrued disability benefits in full, additional assessments may be made.

d. Cash Benefits

Weekly benefits amount to three fourths of the member's weekly salary and are payable after the second day of disability. No benefits are paid for disability arising out of chronic diseases, conditions existing before the member joined the society, nervous or mental diseases, rest cure, a member's indiscretions, confinement due to pregnancy, nor where a member has made a misrepresentation as regards his health on any application.(3) Disability benefits are not paid for more

---

(1) William, Filene's Sons Co., op. cit., Page 6
(2) Ibid, Page 9
(3) Ibid, Page 9

than twenty-six weeks in any year nor during a paid vacation and are paid only upon delivery to the society of a certificate signed by a physician describing the nature of the disability and stating that the member is incapacitated. Seventy-five per cent of the dues collected are set aside for payment of disability benefits and twenty-five for administrative expenses.

e. Conclusions

As can be seen there are many restrictions in regard to receiving the cash benefits which make this part of the plan only worth ten points as is the general quality of the service which has tended to beget malingering and has been lax. The financial arrangements, administration, and eligibility are each worth twenty points making a total of eighty for the plan.

2. New Plan

Until three or four years ago this plan worked fairly well. However, laxity of medical supervision and diagnoses by local physicians not in keeping with the patients' complaints soon became apparent. The patient would stay out longer than necessary and the society had to go to the store for grants in aid. The Federated Department Stores, the owners of Filene's, would not stand for this and consequently in 1945 the Connecticut General Insurance Company took over the plan. (1) The employees pay the same as before and the store contributes money each year. The insurance company receives the illness

---

(1) Gargill, op. cit.

blanks and compensates the individual by giving him two-thirds of his salary for twenty-six weeks illness in one year. No examination of employees is required and unlike the Society Plan, the Insurance Company will pay for the same illness over and over again.(1)

3. Other Medical Services

The store employs three graduate nurses to visit the sick and provides them with a car and gas. If the employee has been sent home sick and has seen no doctor, a visiting nurse will call on him the next day and record her diagnosis. That these nurses have considerable power is shown by the fact that if the nurse finds the employee not at home or drunk instead of sick or for any reason does not consider the complaint bona fide she can stop payment of benefits. Often another nurse is sent out to confirm the decision.(2) Although this inspection by nurses incurs the disfavor of the employee, it is continuing under the new plan, because it is effective in preventing malingering. The clinic physician is still available to advise the employee on medical matters and acts as public health officer but has nothing to do with cash benefits. As a preventive matter, every barber, food handler, beautician, etc. must be examined yearly.(3) Most Filene's employees are also members of the Blue Cross Ward Plan and so together with the cash benefit plan and the medical care offered in the clinic

(1) Gargill, op. cit.
(2) Ibid
(3) Ibid

are fairly well covered. (1) Nevertheless, it is evident that this type of plan is not as good as one which offers complete medical care. Traumatic injuries to an employee or customer are covered by insurance with the Mutual Life Insurance Company and paid for entirely by the store. (2)

The employees want total medical care but do not have the leadership to form a plan, especially when they know that the company is against it, because the company is afraid of being accused of going into medical practice. (3) Regardless, a plan such as that of Filene's is better than nothing and is a step in the right direction. This new plan does not correct the major faults of the old one but merely shifts the burden to an insurance company and so is worth eighty points as was the old plan. They Lynn Riverworks has a mutual benefit association which seems to be working better than that of Filene's as can be seen below.

B. Employee Cash Benefit Plan

Lynn Riverworks of General Electric Company

1. Eligibility and Administration

The employees of the Lynn Riverworks of the General Electric Company do not follow the company plan or Boston Office Plan, (4) but have formed a Mutual Benefit Association to aid themselves in case of disability caused by sickness and

---

(1) Gargill, op. cit.
(2) Ibid
(3) Ibid
(4) See Page 209

accident. Although the General Chairman of the Association is appointed by a General Electric official so that the company has some say in the administration of the plan, this does not give the company enough control to make the plan a joint employer-employee plan. The Association is divided into sections of about two hundred fifty members, each of which has its own officers and Board of Directors and is independent of the others.(1) The Executive Committee which is composed of the chairman of each section, meets quarterly to settle the details of administration of the funds and to appoint an emergency committee which takes action in the meantime and levies extra assessments when necessary.(2) Each section has a Board of Directors consisting of nine members, including the chairman, vice-chairman and secretary, who are elected by ballot and who meet at the call of the secretary, a majority of the directors, or five or more members.(3) An employee is eligible for membership in a section upon recommendation signed by two members, approval of the board of directors, and payment of an entrance fee of fifty cents and the first week's dues of twenty cents.(4)

2. Financial Arrangements

Fees and dues are deducted from the pay and credited to the association in a bank designated by the general chairman. When the amount of the disability fund reaches thirty-five thousand dollars the general chairman may order payment

---

(1) General Electric Mutual Benefit Association. Constitution and By Laws, River Works, West Lynn, Mass., 1937, Page 2
(2) Ibid, Page 4
(3) Ibid, Page 4
(4) Ibid, Page 8

of dues to be discontinued until the fund shall have been reduced to thirty thousand dollars. No member of a section shall be exempt from dues until he has paid dues for at least ten weeks.(1)

3. Cash Benefits

A member disabled through sickness or accident receives cash benefits for fourteen weeks at the rate of twelve dollars per week after an eight day waiting period,(2) unless he is disabled for five weeks or more in which case he is entitled to receive pay for the first week also. He also receives hospital care at three dollars per day for twenty-one days and is exempt from paying dues when disabled.(3)

4. Special Provisions

The following special provisions are interesting: Within three days of notification to the secretary regarding the illness, a visiting committee calls upon the disabled member and reports its recommendation; If payment is not recommended, the Board of Directors investigates; occasionnally a doctor's certificate is sufficient; members are not permitted to leave their place of residence while receiving benefits without first notifying the secretary; benefits may be continued for two years after leaving the employment of the company if no subsequent job has been obtained; and the association cannot be dissolved while ten members object.(4)

(1) General Electric Mutual Benefit Association, op. cit., Page 9
(2) Ibid, Page 9
(3) Ibid, Page 9
(4) Ibid, Page 15

5. Conclusions

The eligibility and membership requirements of this association are restricted to recommended persons and thus worth only fifteen points. The administration, however, is excellent and worth twenty points. The entire burden of financing is on the employee. (Fifteen points) As only cash benefits and no service is offered, this feature of the plan is worth only ten points. The quality of care is normal as in private practice and deserves twenty points, making the whole plan receive a weight of eighty points.

C. Employee Cash Benefit Plan

American Bosch Mutual Benefit Association

1. Origin and Development

Another interesting employee sponsored cash benefit plan is that of the American Bosch Mutual Benefit Association which has among its objectives the providing its members with income when sick or disabled and with extra benefits when confined in accredited hospitals. This association was started in 1934 (1) by a group of employees who had no funds to begin with but who gradually increased their treasury and benefits until they were able to carry out their objectives.

2. Eligibility and Coverage

Any person in the employ of the American Bosch

---

(1) American Bosch Mutual Benefit Association, By Laws, April 1, 1945, Page 3

Corporation is eligible for membership and when approved by the executive board may become a member upon signing an application blank and an order for payment of dues by payroll deduction.(1) Membership terminates with employment and failure to pay dues for four weeks.(2) There were twenty-five hundred subscribers to this plan in 1944,(3) and membership in the association is still growing.

3. Administration

A president, vice-president, and secretary-treasurer are elected annually by the association by ballot as are the members of the nominating committee, the six non-officers on the executive committee, and any other committees formed, such as the investment committee and the investigating committee.(4) Thus a democratic atmosphere prevails.

4. Financial Arrangements

Persons whose average weekly salary is twenty-four dollars or under for a forty hour week fall into Class "A" and pay sixty-five cents per month into the treasury and those who earn over twenty-four dollars fall into Class "B" and pay one dollar per month. All of the contributions are deducted from the pay envelopes.(5) It is interesting to note that unlike most plans, payment of dues is not required under the American

---

(1) American Bosch Mutual Benefit Association, op. cit., Page 4
(2) Ibid, Page 5
(3) Klem, op. cit., Page 44
(4) American Bosch Mutual Benefit Association, op. cit., Page 15
(5) Ibid, Page 14

Bosch Mutual Benefit Association while sickness benefits are being received, because it is realized that during this period the member's income is limited.

5. Cash Benefits

A disabled or sick member must notify within seven days from the commencement of his sickness the secretary-treasurer who in turn notifies the investigating committee. If the latter body so recommends and the executive committee approves the recommendation, the applicant receives for each working day after the first four, ten dollars per week if he is in Class "A" and fifteen dollars if in Class "B" for not more than ten weeks in twelve consecutive months. This benefit is given only if the disability is not the result of "intemperence, immorality, or a voluntary exposure to danger."(1) However, if the illness lasts three weeks or more, the applicant may draw benefit for the first four working days. Also no benefits are paid for pregnancy nor are paid to those who have been members for less than six weeks. A physician's certificate is a necessary prerequisite to collection of benefits. Members confined to hospitals are eligible for hospital benefits of three dollars per day for fifteen days in twelve consecutive months in addition to sickness benefits.(2) If the association ceases to exist, funds are to be disposed of by a two thirds vote of those who have been members in good

(1) American Bosch Mutual Benefit Association, op. cit., Page 12
(2) Ibid, Page 13

standing for a year or more.(1)

6. Conclusion

This is a typical Employee Mutual Benefit Association Cash Benefit Plan and, as all employees are eligible, this feature is worth twenty points as is the administration which is controlled entirely by the employees. The financial arrangements deserve only fifteen points for too heavy a burden is placed on the employees who assume the entire cost. The quality of service is normal as in private practice, depends on the physician chosen by the patient, and is worth twenty points. The cash behefits are too small and therefore this feature deserves only ten points, making a total of eighty-five for this plan.

D. Employee Medical Service Plan
Colonial Beacon Oil Company

Now that employee cash benefit plans have been described, the plan in operation at the Colonial Beacon Oil Company will be discussed as it is a good example of medical service plans which are sponsored by the employees of a company and with which the company executives have nothing to do. The treatment of this plan will be brief, as most of its important features are similar to those of the more complete plan of the employees of the Standard Oil Company of

---

(1) American Bosch Mutual Benefit Association, op. cit., Page 13

Louisiana, the Stanocola Plan, which will be described in greater detail at the end of this chapter and which is the outstanding example of this type of plan. The Colonial Beacon Plan, however, will give a general idea of the nature of employee medical service plans.

1. Eligibility and Coverage

One feature of the plan of the Colonial Beacon Employees' Hospital and Medical Association Inc. which is interesting because of its difference from that of the majority of the other plans herein discussed, is its eligibility requirements, Ordinarily employees and their dependents are eligible for care after one year of membership as subscribers, but persons over forty-five years of age who do not subscribe within a year after employment and dependent children over nineteen years of age are excluded, as are those who do not pass the physical examination required. As a result of these restrictive features only about fifty-eight per cent of the employees are covered by this plan.(1) After three months of membership in the association, subscribers and their dependents are eligible for enrollment for hospitalization and tonsillectomy at home.

2. Financial Arrangements

In any one year the organization will pay up to two hundred dollars for the subscriber and two hundred dollars for

---

(1) Federal Security Agency, Social Security Board, Bureau of Research and Statistics, "Prepayment Medical Care Organizations", Memorandum Number 55, Page 63

dependents unless a maximum has been used for two consecutive years in which case no benefits are payable until one year has passed.(1) The company does not contribute anything toward defraying the costs of operation of the plan. The subscriber has to pay three dollars per month for the first year of membership and two dollars thereafter for himself and three dollars for his family.(2)

3. Scope of Service

The services are rather complete and include: services of a general practitioners in office, home, and hospital; specialist care; surgery, up to one hundred dollars for major surgery and twenty-five dollars for minor surgery; tonsillectomy, for dependents at home up to ten dollars; dentistry, up to twenty-five dollars for X-rays, cleaning and extracting; maternity care after eleven months of membership of the wife; hospitalization up to five dollars and fifty cents per day for up to twenty-one days per person; twenty-one extra days hospitalization for the subscriber at three dollars per day, etc.(3) The quality of the service is up to its usual standards as private physicians are used.

4. Conclusions

The eligibility requirements are too restrictive with respect to age and waiting period and so are worth only ten points. The plan is administered by the Colonial Beacon

---

(1) Federal Security Agency, op. cit., Page 63
(2) Ibid, Page 63
(3) Ibid, Page 63

Employees' Hospital and Medical Association and not controlled by the management of the company and so this feature is worth twenty points. The financing deserves only fifteen points because the employees have to pay everything without any help from the company. However, under the Stanocola Plan which is also entirely sponsored by the employee the company frequently contributes. The scope and quality of service are both good and should each receive a rating of twenty, making the whole plan worth eighty-five points.

E. Employee Medical Service Plan
Standard Oil Company of Louisiana--(Stanocola)

1. Origin and Development

One of the outstanding examples of a medical service plan sponsored by the employees of a company is the Stanocola Plan which was "conceived, organized, and is owned, supported, and operated by the employees."(1) Membership is entirely voluntary and entitles the employee and his family to necessary medical, hospital, and nursing service at one rate of dues from a full time salaried medical staff. The company lends its support by making payroll deductions for dues, permitting the deduction of dues from the company's

---

(1) Adams, James M., "Stanocola Medical Care Plan", Journal of The American Medical Association, Volume 126, Number 6, October 7, 1944, Page 333

thrift fund, donating toward the purchase of its clinic building, and aiding in the administration by having two company executives on the Board of Directors which is elected by the members.(1) The association is entirely distinct from the company's medical department whose work is limited to industrial medicine, preventive medicine, and care of industrial injuries and diseases.(2)

In the early 1920's, the employees of the Standard Oil Company of Louisiana at Baton Rouge suffered a reduction in income. The cost of living in the city was not reduced commensurately with the rest of the country and with the loss of income, and so committees of employees formed to consult business and professional groups seeking a reduction in medical costs. One consulted with a medical society looking toward the return of prewar fees but was unsuccessful.(3) In 1923 an association of thirteen hundred employees was formed to secure medical care at reduced costs and an agreement was made with four physicians whereby the latter would furnish medical care at one half the usual fee and each member would pay one dollar a year.(4) This proved unsatisfactory and was not renewed. The only group plans in the area were those offered by lumber companies to their employees, and under these plans payroll deductions were

(1) Adams, op. cit., Page 333
(2) Ibid, Page 333
(3) Ibid, Page 333
(4) Rorem, C. Rufus and Musser, John H., "Group Payment for Medical Care in the Stanocola Employees' Medical and Hospital Association", Chicago, Illinois, Julius Rosenwald Fund, Page 5

compulsory, doctors were employed, revenues were greater than expenses, and the companies were practicing medicine for profit. The Stanocola employees were against this, and so in 1924, twenty-two thousand employees formed a new association in which for two dollars a month arrangements were made with practitioners to treat eligible beneficiaries in their offices.(1) There was a surgeon medical director, an eye-ear nose throat specialist,and five general practitioners. After six months, offices were rented for a clinic and all the physicians except the surgeon were on full time. Four years later, 1928, the surgeon and medical director became full time employees of the association which then consisted of twenty-eight hundred members, the dues were increased to three dollars per month, and three special assessments were allowed.(2) In 1930 the association was incorporated as a non profit organization with a capital of one hundred thousand dollars, represented by five thousand shares of stock at twenty dollars each. Each member was required to purchase one share and the funds were to be used for improvements. These shares had no voting power but had value in case of liquidation.(3) In 1931, a large residence was purchased for a clinic.(4)

2. Eligibility and Coverage and Administration

Membership is voluntary and limited to white

---

(1) Adams, op. cit., Page 333
(2) Ibid, Page 333
(3) Ibid, Page 333
(4) Ibid, Page 333

employees. A board of directors is elected and consists of eight members representing special departments and three members at large, all of whom serve for two year overlapping terms. The president, two vice-presidents, and the secretary-treasurer are elected annually. The secretary is a member of the board and serves as executive officer and treasurer and receives a salary. New employees may join immediately but dependents must wait ninety days.(1)

3. Financial Arrangements

The dues are three dollars per month for employees and one dollar per month for dependents other than wife and children and parents.(2) In 1931, the service cost ninety-two thousand, two hundred and forty-five dollars and eighty cents, sixty-three per cent of which was for doctors' services and clinic expenses, twenty-seven per cent for hospital expenses, and ten per cent for special nurses. All this was secured from the dues.(3) The clinic which costs fifty-eight thousand dollars per year would cost one hundred thousand dollars in private practice.(4) Table 26 on Page 250 shows further figures on the disbursement of revenue of the Stanocola Plan.

4. Personnel and Facilities

The personnel consists of eleven full time and five part time doctors, the former including two surgeons,

---

(1) Rorem and Musser, op. cit., Page 7
(2) Reed, Louis, "Costs and Benefits Under Prepayment Medical Service Plans", Social Security Bulletin, Volume 13, March, 1940, Page 25
(3) Rorem, op. cit., Page 19
(4) Ibid, Page 22

TABLE 26

Stanocola Plan--Disbursement of Revenues 1936-1942

Purpose	Percent of Revenue	Monthly Cost Per Member	Monthly Cost Per Beneficiary
Doctor's Salary	40%	$1.40	$0.36
Hospital	20%	$ .70	$ .18
Special Nurses	10%	$ .35	$ .09
X-ray Department	6%	$ .21	$ .06
General and Administrative Expenses	18%	$ .63	$ .16
Other Expenses	5%	$ .17	$ .04
To Surplus	1%	$ .04	$ .01
TOTAL	100%	$3.50	$ .90

Source - Adams, James M., "Stanocola Medical Care Plan", Journal of the American Medical Association, Volume 26, Number 6, October 7, 1944, Page 335

one X-ray technician, two office girls, a cleaning staff, and some clerks to answer the phone at night. All the physicians are graduates of approved medical schools and are members of the American Medical Association, and many have postgraduate training. There are seven office suites in the clinic and the hours of the physicians are staggered. There are also clinical and X-ray labs, physical therapy treatment rooms, a pharmacy and a dental unit.(1) The physicians have good working conditions and are very adequately remunerated as evidenced by the fact that even in the depression years of 1929-31 the Medical Director got nine thousand dollars a year, the eye-ear-nose-throat specialist six thousand dollars,

---

(1) Adams, op. cit., Page 334

and the general practitioners six thousand dollars each.(1) Each doctor gets one day off a week and two weeks vacation a year as well as time to attend professional association meetings.(2)

5. Scope of Service

The medical and surgical service is limited only by the capacity of the staff. The patients may be treated in the clinic, in the hospital, or in their homes if within a seven mile radius of the clinic, a mileage fee being paid by the patient beyond this point. Hospitalization is provided in the wards except where privacy is necessary as in the case of contagious diseases or where the patient pays the difference between a private and a ward room. The General Hospital in Baton Rouge is used as special rates are given to the association. Special nurses are used when necessary, the cost of the hospital and nursing service being limited to two hundred and fifty dollars per case. Obstetric cases go to the hospital for delivery at the patient's expense; medicine is not administered in the clinic; and eyeglasses and crutches and artificial limbs are not supplied. Services are the same for employees and dependents.(3) The patient may select any member of the staff to diagnose and treat his condition except the chief.

---

(1) Rorem, op. cit., Page 10
(2) Ibid, Page 10
(3) Adams, op. cit., Page 334

6. Volume of Service

The volume of service fluctuates with the number of eligibles. In 1931, there were thirty-one thousand, four hundred and ninety-four visits to the clinic or an average of four visits per person; house visits amounted to two thirds this number, the total being twenty-five thousand, eight hundred and thirty-eight; there were one thousand and fifty-four patients in the hospital in 1931; and the average length of stay was five and four tenths days or a total of five thousand, six hundred and ninety.(1) Table 27 on Page 253 shows other interesting figures on the volume of service.

7. Quality of Care

Dr. John H. Musser has made a study of the quality of the service offered by the Stanocola Plan and it would be worth while to see what a physician considers as important points in quality of service, as the same type of study would be applicable to all the plans discussed in this thesis. The physical arrangement of the clinic is good, it being well lighted and equipped for diagnosis and treatment, spacious and well constructed. The offices are used alternately and so are occupied all day. The clinic laboratory has complete equipment except for Wassermann tests and X-rays for which purposes the hospital labs are used.(2) However there should be more blood counts taken in the lab according to Dr. Musser. Nevertheless the

---

(1) Rorem, op. cit., Page 15
(2) Ibid, Page 28

TABLE 27

Stanocola Employees' Medical and Hospital Association Incorporated Statement of Work by Year from January 1, 1925-December 31, 1931

	Number of Cases Per Year						
Service	1925	1926	1927	1928	1929	1930	1931
Work at Clinic:							
Office consultations and Examinations	17,984	25,977	24,043	25,542	30,976	33,796	31,494
Salvarsan Injections	3,386	504	391	193	186	192	157
Circumcisions	35	36	81	51	32	41	39
Cystoscopies	27	75	61	76	37	83	85
Miscellaneous Minor operations	165	504	772	622	494	501	458
Physical Therapy			632	642	1,131	1,466	1,311
Metabolism Tests				86	80	96	75
Lab Specimens	3,357	4,284	4,994	4,546	4,987	5,722	5,433
Residence Visits: (Including Visits to Hospitals)	33,139	15,657	16,863	19,354	21,780	27,277	25,838
Obstetrical Cases	173	253	271	234	251	232	174
Work in Hospital:							
Total Hospital Admissions	746	793	1,085	1,098	1,061	1,235	1,054
Major Operations	239	303	385	183	159	179	181
Minor Operations (Exclusive of Tonsils and Adenoids Removals)	208	277	380	203	318	355	259
Tonsils and Adenoids Removals				383	310	317	297
Medical Cases	105	150	210	258	274	319	255
Hospital Cases Attended by Outside Physicians	92	63	90	71		65	62
Ether Anesthetics	345	369	531	500	366	326	435
Members of Association	2,200				2,800		2,650

Source - Rorem, C. Rufus, and Musser, John H., "Group Payment for Medical Care in the Stanocola Employees' Medical and Hospital Association", Julius Rosenwald Fund, New York, 1935, Page 16

general practitioners are able to treat every type of illness at the clinics at a rate of about twenty-five patients in three hours and encounter few diagnostic difficulties. House visits are made more often than by independent practitioners treating similar cases because visits are made when necessary, not just when called for by the patient. The physician sees the patient as soon as his illness develops and is therefore often able to make an early diagnosis.(1) The surgical service is excellent as is that from the eye-ear-nose-throat specialist. Preventive medicine is practiced in the form of inoculations, circumcisions, health examinations, etc.(2) The fact that records are incomplete and autopsies low might be criticised. The treatment for ambulatory cases is adequate and for hospitalized cases excellent, and the close personal relationship between the doctor and patient is kept, there being excellent team work and cooperation among the physicians and an inspiring leadership. Staff meetings are held at which members read medical papers. The lay group does not dictate to the physicians.(3) The service is remarkable for the financial outlay although some of the doctors tend to care for too large a group. The fact that the doctors are free from financial worries, have daily contact with physicians, and have time off and vacations without loss of income is very helpful.(4)

(1) Rorem, op. cit., Page 28
(2) Ibid, Page 28
(3) Ibid, Page 28
(4) Ibid, Page 28

8. Conclusions and Advantages

The quality of service exemplified by this plan might well serve as a model for other plans and certainly deserves a rating of twenty out of twenty as do the eligibility, administration, financial arrangements, and scope of service. Thus this plan is worth one hundred points and stands with those of the Endicott-Johnson,(1) American Tobacco Company,(2) American Cast Iron Pipe,(3) and Kaiser(4) Plans as one of the few plans offering complete and excellent medical service.

It might be well to analyze some of the advantages of a plan of this type. The member receives medical, hospital, and nursing care for himself and his family at a predetermined cost, is supplied with service superior to that received by persons in the same economic group, escapes debt from medical or hospital bills, and does not have to receive charity. The employer gets the advantage of having his employees return to duty with a minimum loss of time because of the adequate care which they receive, of having close cooperation between the company's medical department and the employees' physicians, of finding it easier to persuade employees to correct their physical defects, of having the fraudulent claims of industrial injury reduced, and of having the employees' morale improved by being free from worry over the cost of illness and by having

---

(1) See Page 194
(2) See Page 199
(3) See Page 201
(4) See Page 221

the satisfaction of being provided with excellent medical care through their own efforts. The medical staff physician receives compensation higher than the normal average, avoids the inconvenience of individual business, has days off and vacations with pay, can have postgraduate training at the association's expense, and is stimulated to better work by close consultation with other physicians. Thus it can be seen that this plan comes close to the ideal method of solving the problem of "Medical Insurance in Industry" and should be copied elsewhere as should many non-contributory, joint employer-employee and other employee plans if it is the desire of industry to obviate the necessity of government control and increased taxation and supervision.

Chapter IX will be devoted to a comparison, according to the weight system described above, of the various plans discussed herein and to general conclusions and recommendations.

CHAPTER IX

CONCLUSION

A. The Present Situation

Before summarizing and comparing the details of the various plans described herein it might be well to get a picture of the medical situation as it is today. This was described in more general terms in Chapters I and V before all the individual plans were discussed. Now with the latter as a basis, a more complete treatment can be made.

In 1943, there were two hundred and nineteen prepayment organizations in thirty-five states, the District of Columbia, and Hawaii.(1) These plans differ widely, some being financed by the employer and others by the employee, some offering medical service and others making extra charges etc.

1. Eligibility and Coverage

First, as to eligibility and coverage, over three million persons or three per cent of the non institutional population of the United States are protected through two hundred and fourteen prepayment plans,(2) as can be seen from studying Table 28 on Page 258. This does not include seventeen million Blue Cross subscribers, hospitalization plans, Farm Security Administration Plans, College Students,

(1) Federal Security Agency, op. cit., Page 112
(2) Ibid, Page 112

TABLE 28

Number of Persons Eligible for Care Under Prepayment Medical Care Organizations and Number of Physicians and Nurses Associated with Such Organizations by Type of Organizations (Based on Two Hundred and Fourteen Organizations Furnishing Data in 1943)

Type of Organization	Number of Organizations	Persons Eligible for Care					Physicians and Nurses Associated with Organizations			
		On Prepayment Basis			Total Including Those Eligible on Prepayment Basis		Physicians			Full Time Registered Graduate Nurses
		Subscribers	Dependents	Total	Number	Percent	Full Time	Part Time	Participating	
TOTAL	214	1,786,025	1,170,025	2,956,786	3,320,408	100.0%	836	6,551	24,756	2,148
Industrial	113	866,014	318,261	1,184,275	1,425,325	42.9%	508	5,872	149	1,471
Medical Societies										
Washington and Oregon	15	229,247	900	230,147	230,147	6.9%	1		1,516	
Other States	18	229,313	412,352	711,665	711,665	21.5%	22		18,751	46
Private Group Clinics	24	212,563	163,130	375,693	490,980	14.8%	235	466	60	314
Consumer Sponsored	29	74,950	94,606	169,566	176,841	5.3%	52	211	3,550	194
Governmental	12	87,443	155,852	243,295	243,295	7.3%	16	2	730	122
Unclassified	3	16,495	25,660	42,155	42,155	1.3%	2			1

Source - Federal Security Agency, Social Security Board of Research and Statistics, "Prepayment Medical Care Organizations--Statistical Summary", Memorandum Number 55, June, 1944, Page 117

Members of the Armed Forces, Veterans Administration, Workmen's Compensation, Commercial Insurance, Industrial Plans, the Rhode Island Plan for public assistance, etc. Eighteen thousand industries insure eighteen million (1) employees at least partially against the hazards of illness. There are no available figures on total coverage. Some of these plans, in order to prevent adverse selection, have restrictions as to age, physical condition, income, type of illness, etc. Although one quarter of the plans have no restrictions as shown in Table 29 on Page 260, medical society plans usually have restrictions as to age and income. (2)

2. Administration

As for distribution by type of organization (administration) it was shown in Table 28 on Page 258 that forty-three per cent are industrial plans, twenty-eight per cent medical society plans, fifteen per cent private group clinic plans, seven per cent government plans, and five per cent consumer sponsored plans; the other two per cent constitute miscellaneous plans. (3) Geographically speaking, all but twelve states and Alaska have plans. New England has the smallest number of plans and the smallest coverage in absolute numbers in relation to population, two per cent of the population being eligible. (4) Ten per cent of the population of

(1) Fishbein, M., "Medical Insurance Plans--Which System Will Guarantee the Best Medical Care", Vital Speeches, Volume II, Number I, January, 1945, Page 191
(2) Federal Security Agency, Social Security Board, Bureau of Research and Statistics,op. cit., Page 113
(3) Ibid, Page 112
(4) Fishbein, op. cit., Page 19

TABLE 29

Number of Prepayment Medical Care Organizations Having Specified Membership Restrictions by Type of Organization (Based on Two Hundred and Fourteen Organizations Furnishing Data in 1943)

	Type of Organization	Total Number of Organizations	Number Having None of Three Types of Restrictions	Number Having Only One of Three Types of Restrictions			Number Having Only Two of Three Types of Restrictions			
				Entrance Physical Examination	Age Restrictions	Income Limitation	Entrance Physical Examination and Age Restriction	Age Restriction and Income Limitation	Income Limitation and Entrance Physical Examination	Number Having All Three Types of Restrictions
	TOTAL	214	52	71	26	10	33	11	3	8
I.	Organizations Providing Care to Subscribers Only:									
1.	Industrial	71	11	40	2	4	10		2	2
2.	Medical Societies:									
a.	Washington and Oregon	14	4	4			1	2	1	2
b.	Other States	1						1		
3.	Private Group Clinics	4	2		1	1				
4.	Consumer Sponsored	4	1		1		2			
5.	Governmental	1		1						
II.	Organizations Providing Care to Subscriber and Dependents:									
1.	Industrial	42	7	17	5	1	11	1		
2.	Medical Societies:									
a.	Washington and Oregon	1								
b.	Other States	17	1		8	2				
3.	Private Group Clinics	20	4	3	2		1	6		
4.	Governmental	11	7	3			3	1		1
5.	Unclassified	3			3					1

Source - Federal Security Agency Social Security Board, Bureau of Research and Statistics, "Prepayment Medical Care Organizations--Statistical Summary", Memorandum Number 55, June, 1944, Page 120

Washington, Oregon, and California are covered.(1) Thus there is much room for expansion in New England. The number and distribution of physicians associated with prepayment plans is indicated in Table 28 on Page 258. In 1943, there were approximately thirty-two thousand physicians serving two hundred and fourteen plans, eight hundred and thirty-six full time, six thousand five hundred part time, and twenty-five thousand accepting members as patients under prepayment contracts.(2) This is one third of all the physicians in the United States. Of the eight hundred and thirty-six full time physicians, five hundred and eight served industrial plans, two hundred and thirty-five private group clinics, fifty-two consumer sponsored plans, and twenty-three medical society plans (one in Washington and twenty-two in California).(3) It is interesting to note that industrial plans absorb ninety per cent of the part time physicians and that one third of the thirty-two thousand physicians serve on the Pacific Coast.(4) Again New England makes the poorest showing in this respect and should take steps to improve this condition. Industrial plans also hire over half of the two thousand, one hundred and fifty-seven nurses employed by the two hundred and fourteen organizations and the majority of these also serve on the Pacific Coast.(5) From the above figures it can be seen that the western part of the country is more advanced than the east in the development of "Medical Insurance in Industry."

(1) Fishbein, op. cit., Page 19
(2) Federal Security Agency, op. cit., Page 113
(3) Ibid, Page 113
(4) Ibid, Page 114
(5) Ibid, Page 114

3. Financial Arrangements

Not much can be said in a general way concerning the financial arrangements of the plans existing today as they differ in amount and distribution of burden. However, on the whole they are adequate and not over burdening.

4. Scope of Service

Services provided by many of the plans include: that of the physician in the office, home, and hospital for medical, surgical, and maternity cases; that of nurses, visiting, hospital, and special duty; X-rays and lab service; drugs and medicine; and dental care. All these services vary greatly with the organization as shown on Table 30 on Page 263. There are limitations regarding total money value received for a single illness in a single year, separate charges for the first treatment of each illness and for home calls, limits to the number of days of hospitalization, exclusions for particular diseases, etc. (1) The quality of service is uniformly good. Tables 28, 29, and 30 on Pages 258, 260, and 263 will give a more complete picture of the present situation. The following comparison of the various plans discussed will give a still more complete picture and should be of aid to those starting or reorganizing plans for "Medical Insurance in Industry".

B. A Comparison of the Plans and Weights

---

(1) Federal Security Agency, op. cit., Page 115

Table 30

Number of Persons Eligible for Specified Services Under Prepayment Medical Care Organizations By Type of Organization (Based on Two Hundred and Fourteen Organizations Furnishing Data in 1943)

Type of Organization	Number of Persons Eligible for Care on a Prepayment and Reduced Fare Basis	Hospitalization Provided and Physicians Services					No Hospitalization Provided Physician's Services Provided					Dental Care			
				In Hospital Only			In Home and Office:			In Hospitals Only		Substantial Amount		Minor Amount	None
							Physicians also give care in Hospital								
		For Medical and Surgical Cases in Home, Office and Hospital	For Medical and Surgical Cases in Home and Office only	For Medical and Surgical Cases	For Surgical Cases Only	No Other Service	For Medical and Surgical Cases	For Medical Cases Only	In Home and Office Only	For Medical and Surgical Cases	For Surgical Cases Only	On Prepayment* Basis	On Reduced Fee Basis		
TOTAL	3,320,408	2,168,417	9,025	77,350	77,043	114,253	119,260	33,786	82,678	94,550	549,046	503,683	348,460	940,332	1,527,933
Industrial	1,425,325	1,143,556	9,025	7,906	44,988	114,253	32,053	4,986	68,548			149,699	267,992	541,423	466,211
Medical Societies:															
Washington and Oregon	230,147	230,147												189,147	41,000
Other States	711,665	59,742					9,826	3,039		90,808	548,260				711,665
Private Group Clinics	490,980	379,120		68,844			21,729	24,287				100,000	73,831	156,888	160,561
Consumer Sponsored	176,841	101,057					55,652	1,474	14,130	3,742	786	24,484	6,637	36,377	105,383
Governmental	243,295	243,295										225,500		16,797	998
Unclassified	42,155	11,500		3,600	27,055										42,155

Source - Federal Security Agency, Social Security Board, Bureau of Research and Statistics, "Prepayment Medical Care Organization--Statistical Summary", Memorandum Number 55, June, 1944, Page 121

1. Basis of Comparison

Comparing the various plans herein discussed is not an easy task because they are all so different. Perhaps the best method of comparison is by the five or six outstanding features of plans in general. This method was used in studying the various plans discussed herein and in interviewing medical men and the following points were considered:

(1.) Origin and Development
    a. By whom is plan organized? (company or employees or both or outside agency)
    b. What is general nature?
(2.) Eligibility and coverage
    a. Is membership voluntary or compulsory?
    b. Are there limitations as to age, color, physical condition, number of dependents, income, service, etc.?
    c. What is per cent of employees covered?
(3.) Administration
    a. Are patient and physician represented?
    b. Who controls medical service?
(4.) Financial Arrangements
    a. What are member's subscription rates?
    b. Are there special fees and surcharges?
    c. What are employer's contributions if any? Are there any outside funds which contribute?
    d. What is the method of paying for medical

service? (Payroll deductions or direct payment)

e. What are average costs?

(5.) Scope of Service

a. What services are given?

b. Are services complete or emergency?

c. Does the plan cover men only while at work?

d. Does the plan provide cash benefits in lieu of wages?

e. Is there a limitation according to amount paid?

f. Is medical, hospital, and nursing service provided?

g. Is home service offered?

h. May any employee join?

i. For how long is cash benefit paid, if any? How much?

j. Is there a waiting period?

k. Are examinations required?

l. Are X-ray and laboratory facilities offered? Are pharmacy benefits provided?

m. Are specialists' services offered?

n. Is there free choice of physicians?

o. What are the medical benefits? Of what does the preventive and diagnostic service consist?

p. Is there provision for tuberculosis?

q. Is surgery provided?

r. Is maternity service provided?

s. Is pediatrics offered?

t. What are the hospitalization benefits?

u. Is dental care offered?

v. Are drugs, dressings, and appliances provided?

(6.) Quality of service

a. What are the qualifications of physicians--state license, graduate of Grade A medical school, medical society, hospital affiliations, special training, services, etc.?

b. Is there free choice by patient?

c. Is physician remunerated by panel, fee, or salary? Does physician serve full or part time?

d. What are case load and working conditions?

e. Are there research opportunities?

f. Is there medical or lay control?

g. How are complaints handled?

h. Is there much preventive service?

i. Is diagnosis good?

j. Are facilities complete?

k. Is group practice used?

All plans do not have all these features and so cannot be compared on the basis of all the above points. Nevertheless, in investigating the possibilities of a particular plan, all these points as well as the advantages of the plan to the members, employer, and physician should be considered. It cannot be determined definitely whether or not a particular

plan meets the general problem of "Medical Insurance in Industry" or not. However, all the plans discussed in this thesis contribute their bit to the increasing of medical coverage and the distributing of the cost.

2. Comparison of Plans

The original table entitled "Comparison of Forty Weighted Plans by Types and Qualities" which can be found on the next page is comprehensive in scope in that it not only compares the forty individual plans rated herein but also compares each feature of each plan. Perhaps more can be learned from a study of one feature through each plan than from a comparison of the total weight of the plans because, as was explained before, the total weights are fairly constant although the best plans show slightly higher totals. The plans are arranged on the table approximately in the order in which they were discussed in the text of this thesis, that is by type. As it might be interesting to discuss the separate features in the order of the weights assigned to the plans for these features, this has been done in table form in Appendix I. (1) As mentioned in the introduction, eligibility and coverage, administration, financial arrangements, scope of service, and quality of care each have been arbitrarily assigned a weight of twenty points. Each of these features of a particular plan have been given a weight of ten, fifteen, or twenty depending upon how nearly they meet the desired standards. An expert can adapt this

---

(1) See Page 287

Table 31

Comparison of Forty Weighted Plans by Types and Qualities

Plan	Text Page	Type	Wgt	Eligibility and Coverage Restrictions	Wgt	Administration Representation	Wgt	Financial Arrangements Contributors	Wgt	Scope of Service Completeness	Wgt	Quality of Care Evaluation	Total Wgt	Conclusions Remarks
New York City	44	Voluntary local government (proposed)	20	No restrictions. Everyone in city eligible.	20	Physicians and subscribers represented	20	Employer and employee share	20	Complete medical service	20	Good--Medical Research standards Board	100	Complete service, cost shared by employer and employee
Rhode Island State	49	Compulsory state government	15	Waiting period	15	Subscribers not represented	20	Employer and employee share	10	Only cash benefits for wages lost	20	Normal as in private practice	80	Only cash benefit. Subscriber not represented. Only state plan.
The Model Bill	57	Voluntary state government (proposed)	15	Occupational and service restrictions	10	Physicians and subscribers not represented	20	State, employer, and employee share	20	Complete medical service	20	Normal as in private practice	85	Not representative. Too restrictive
Wagner-Murray-Dingell Bill	61	Compulsory federal government proposed.	20	No restrictions. Everyone in country eligible.	10	Too much power in Surgeon General's hands	15	Charges too high. Employer employee share	20	Complete medical service	20	Good--Extensive facilities; medical standards	85	Too much central control. Charges too high.
Denmark	72	Voluntary National	20	No restrictions. Everyone in country eligible.	15	Subscriber not represented	20	State, employer employee share	15	Limited service	20	Normal as in private practice	90	Limited service. Subscriber not represented.
Germany	75	Compulsory National	15	Occupational restrictions.	10	Too bureaucratic	20	Employer and employee share	20	Complete medical service	20	Good facilities and personnel	85	Too bureaucratic and restrictive.
Great Britain	81	Compulsory National	15	Dependents not included	20	Physicians and subscribers represented	20	State, employer, employee share	15	No specialist lab or dental care	15	Panel system. Inadequate attention	85	Good administration. Coverage and service should be extended
France	84	Compulsory National	15	Income restrictions	15	Administered with confusion	20	State, employer employee share	15	Limited to cash benefit	20	Doctors not restricted	85	Income restrictions. Only cash benefits. Confused administration.
Russia	92	Compulsory National	20	No restrictions. Everyone in country covered.	10	Completely controlled by government	20	State finances	20	Complete medical service	20	Modern hospitals Government standards	90	Complete service free. Controlled by government.
New Zealand	93	Compulsory National	20	No restrictions. Everyone in country covered.	15	Administered by Ministry of Health	15	Charges too high. Employee and state share	15	Incomplete service	20	Doctors not restricted	85	Non representative administration. Charges too high. Limited service.
Blue Cross	101	Voluntary non-profit private association	15	Income restrictions. Increasing coverage	15	Subscriber not represented	15	Burden entirely on subscriber	15	Doctors service only in hospital	20	Good care by hospital staff	80	Coverage increasing. Financial burden on unrepresented subscribers.
Michigan Mutual Health Service	110	Medical society	15	Few subscribers More than other medical societies.	15	Subscriber not represented. Controlled by Drs.	15	Burden entirely on subscriber	10	Limited to surgery and obstetrics	20	Good--offered by qualified doctors	75	Small coverage. Only surgery and obstetrics. Subscriber pays all.
California Physicians'	113	Medical Society	10	Income limitations. Few subscribers.	15	Subscriber not represented. Controlled by Drs.	15	Burden entirely on subscriber	10	Limited to surgery and obstetrics	20	Good--offered by qualified doctors	70	Income limitations. Financed by non represented subscribers. Limited service.
Massachusetts Blue Shield	116	Medical Society	10	Income limitations. Few subscribers.	20	Drs.,Public, and Subscriber represented	15	Burden entirely on subscriber	10	Limited to surgery and obstetrics	20	Good--offered by qualified doctors	75	Small coverage. Representative administration. Limited service + eligibility
New Jersey Medical Surgical	120	Medical Society	10	Restricted to hospital patients. Few subscribers	15	Subscriber not represented. Controlled by Drs.	15	Burden entirely on subscriber	10	Limited to surgery and obstetrics	20	Good--offered by qualified doctors	70	Small coverage. Financed by non represented subscribers. Limited service.
Ross-Loos Clinic	126	Private Group Clinic	15	Only those between 21-50 are eligible.	15	Subscriber not represented	15	Charges too high	20	Complete medical service	20	Good staff	85	Limited eligibility and service. Non representative.

Table 31 (continued)

Plan	Text Page	Type	Wgt	Eligibility and Coverage Restrictions	Wgt	Administration Representation	Wgt	Financial Arrangements Contributors	Wgt	Scope of Service Completeness	Wgt	Quality of Care Evaluation	Total Wgt	Conclusion Remarks
Tampa, Florida	128	Cooperative	20	No restrictions All members of group eligible	20	Members represented	20	Financed by membership dues	15	Not complete medical care	10	Inferior, overworked, under paid physicians	85	Poor quality and incomplete service
International Ladies' Garment Workers	135	Union	20	All members eligible	20	Administered by consumers' representatives	20	Covered by union dues	10	Limited. Hospitalization and operation excluded.	15	Cumbersome procedure	85	Administered by consumer. Limited service.
Cafeteria Employees' Union	142	Union	10	Waiting period Age limit 18-50 Physical exam.	20	Administered by subscribers	20	Small fees	15	Limited service	20	Good staff	85	Restricted eligibility. Limited service
International Workers Order	143	Union	20	No restrictions All employees eligible.	20	Representative. Consumer sponsored.	15	Too many extra charges	10	Too limited	20	Good staff	85	Too many extra charges. Limited service
Insurance Companies	148	Commercial Insurance	20	No restrictions All group members eligible.	10	Completely in hands of company and impersonal	20	Employer and employee share	10	Only cash benefit	20	Normal as in private practice	80	Subscriber not represented. Only cash benefits
Prudential Insurance Co. of America	154	Commercial Insurance	20	No restrictions All group members eligible.	10	Completely in hands of company and impersonal	20	Employer and employee share	10	Cash benefits and limited hospital care	20	Normal as in private practice	80	Subscriber not represented. Cash and limited service.
New England Telephone and Telegraph Co.	185	Non Contributory Cash Benefit	10	Two year waiting period.	20	Employees pay nothing so need not be represented	20	Employer pays all	10	Limited to cash and minor treatment	20	Normal as in private practice	80	Free, limited service, long waiting period
Boston Edison Company	189	Non Contributory Cash, Hospitalization and Surgical Benefit	15	One year waiting period	15	Subscriber not represented tho pays for dependents	20	Employer pays for employee not dependents	15	Hospital and surgical benefits and cash but not medical service	20	Normal as in private practice	85	Waiting period and limited service
Endicott Johnson Company	194	Non Contributory Medical Service	20	No restrictions All employees eligible.	20	Employee pays nothing so need not be represented.	20	Employer pays all	20	Complete medical service	20	Picked staff. Complete facilities	100	Complete service at no cost to employee
American Tobacco Company	199	Non Contributory Medical Service	20	No restrictions All employees eligible.	20	Employee pays nothing so need not be represented.	20	Company pays all	20	Complete medical service	20	Good staff	100	Complete medical care free
American Cast Iron Pipe Company	201	Non Contributory Medical Service	20	No restrictions All employees eligible.	20	Employee pays nothing so need not be represented.	20	Company pays all	20	Complete medical service	20	Preventive services	100	Complete service free
Paraffine Company	204	Non Contributory Medical Service	20	No restrictions All employees eligible.	20	Employee pays nothing so need not be represented.	20	Company pays all	10	Service limited to general practitioner care	20	Good staff	90	Limited service. Only general practitioner care
Batchelder and Snyder Company	206	Joint Employer-Employee Cash Benefit	20	No restrictions All employees eligible.	15	Subscriber not represented tho pays for dependents and self	15	Charges high for services rendered. Cost shared.	10	Cash benefits only	20	Normal as in private practice	80	Only cash benefit. High charges
General Electric Company	209	Joint Employer-Employee Cash Benefit	20	No restrictions All employees eligible.	15	Employee not represented tho pays for dependents and self	15	Charges high for services rendered. Cost shared.	10	Cash benefits only	20	Normal as in private practice	80	Only cash benefit. High charges
Dunn and McCarthy Shoe Factory, Binghampton, New York	211	Joint Employer-Employee Medical Service	15	Waiting period	20	Mutual benefit society	20	Employer-employee share on 1/3, 2/3 basis	15	Not complete	20	Normal as in private practice	90	Eligibility restricted. Service incomplete

Table 31 (continued)

Plan	Text Page	Type	Wgt	Eligibility and Coverage Restrictions	Wgt	Administration Representation	Wgt	Financial Arrangements Contributors	Wgt	Scope of Service Completeness	Wgt	Quality of Care Evaluation	Total Wgt	Conclusion Remarks
Consolidated Edison of New York	214	Joint Employer-Employee Medical Service	15	Dependents not included	20	Subscriber administers thru mutual benefit society. Medical service under doctors.	20	Employer and employees share	15	Hospitalization not included	20	Normal as in private practice	90	Family members excluded. No hospitalization
Tennessee Coal, Iron, and Railroad	215	Joint Employer-Employee Medical Service	20	No restrictions. All employees eligible	10	Physician and subscriber not represented.	20	Employer and employees share	15	Extra charge for hospital and specialist service	20	Good facilities and personnel	85	Company administers tho employee shares cost and pays extra for hospitalization.
Tennessee Valley Authority	218	Joint Employer-Employee Medical Service	20	No restrictions. All employees eligible	20	Subscribers repsented	20	Employer and employee share	15	Incomplete medical service	20	Well trained personnel and good facilities	95	Extra charges for dependents, incomplete service.
Henry J. Kaiser (N. Permanente Foundation)	221	Joint Employer-Employee Medi-Service	20	No restrictions. All employees eligible	20	Physicians and subscribers represented	20	Employer and employee share	20	Complete medical service	20	Excellent facilities and staff	100	Complete service. Cost shared by employer and employee
William Filene's Sons Company	232	Employee Cash Benefit	20	No restrictions. All employees eligible	20	Subscribers administer	20	Employee pays most, helped by employer	10	Cash benefits, Only. Too many restrictions	10	Cumbersome, malingering	80	Only cash benefits, Too much malingering
Lynn Riverworks of General Electric	237	Employee Cash Benefit	15	Recommendation necessary	20	Mutual benefit association administers	15	Burden entirely on subscriber	10	Cash benefits only	20	Normal as in private practice	80	Employees administer and support. Cash benefits only.
American Bosch Company	240	Employee Cash Benefit	20	No restrictions. All employees eligible	20	Mutual benefit association administers	15	Burden entirely on subscriber	10	Service not complete. Cash too small.	20	Normal as in private practice	85	Employee pays all. Benefit too small.
Colonial Beacon Employees Hospital and Medical Association Inc.	243	Employee Medical Service	10	Too restrictive. Waiting period. Age requirement. Physical examination	20	Administered by employees association	15	Burden entirely on subscriber	20	Complete medical service.	20	Normal as in private practice	85	Eligibility restrictions. Employee manages and finances.
Standard Oil Company of Louisiana (Stanocola)	246	Employee Medical Service	20	No restrictions. All employees eligible	20	Subscriber and physician represented	20	Employee pays most, helped by employer	20	Complete mediccal Service	20	Early diagnosis. Group cooperation. Good facilities	100	Complete medical service. Cost shared, representative.

Source - Original

chart to his own needs merely by assigning a different proportionate weight to the features. For example, the Massachusetts Blue Shield Plan (1) has been rated herein ten, twenty, fifteen, ten, and twenty respectively for the five features or a total of seventy-five. If the expert should decide that instead of twenty points each, the features should receive twenty, ten, ten, forty, twenty respectively,this plan would be worth ten, ten, seven and five tenths, twenty, twenty or a total of sixty-seven and five tenths.

a. Eligibility and Coverage

It is interesting to note that twenty-two of the forty plans have received a weight of twenty points for eligibility, twelve have received fifteen points, and six are worth ten points. A list of these plans, their type, their weight, and the reason for this rating may be found on Table 32 on Page 288.

Among the reasons for deducting five points and giving a weight of fifteen are a waiting period, occupational and service restrictions, small coverage, recommendation requirements, etc.

Those plans which have exceptionally long waiting periods or low income maximums, and those plans which impose several restrictions have been given a rating of ten for eligibility and coverage. As can be seen, most plans have made a fairly creditable rating for this feature.

(1) See Page 116

b. Administration

The administrative feature seems to be rated fairly highly as can be seen from the fact that twenty-one of the forty plans were rated twenty, twelve of them fifteen, and seven plans ten.

The administration Table, Number 33 on Page 289 indicates that physicians and subscribers are represented on the administrative boards of these plans which have been rated twenty, except where the employee does not contribute anything toward the support of the plan.

Five points are deducted when the subscriber is not represented or when the plan is administered with confusion.

A rating of only ten is received if neither the physician nor the subscriber is represented, if too much power is had by a central authority, if the administration is too bureaucratic, or if the control is completely in the hands of the company.

c. Financial Arrangements

Of the plans examined herein, those with good financial arrangements seem to be about twice as numerous as those with minor defects, there being twenty-six plans deserving twenty points each and fourteen plans, fifteen points.

As can be seen in Table 34 on Page 290 both those

plans in which the employer bears the whole cost and those in which the employee shares the burden have been given a rating of twenty points, it being felt that the mere fact that the employee pays something for the benefits he receives does not necessarily make the financial arrangements worth any less.

Fifteen points were alloted to those plans which charge the employee too much and to those in which the entire burden is borne by the subscriber.

d. Scope of Service

The scope of service is perhaps the most important feature of a plan as the goal is complete coverage. As can be seen from Table 35 on Page 291, twelve of the forty plans have been alloted twenty points, twelve fifteen points, sixteen ten points. It is interesting to note that more plans fall down on this feature than the others.

Those plans offering complete medical service have been given a rating of twenty for scope of service.

However, only fifteen points have been given those plans which do not provide specialist's care, lab service, and dental care; those which are limited to cash for a certain period of time; those which do not provide the services of the physician outside the hospital; those which

impose extra charges for hospital or specialist care; and those which exclude hospital benefits, etc.

Plans which offer only cash benefits, which are limited to surgery and obstetrics, or which exclude hospitalization and operations have been given a rating of ten points. It can be seen that there is much room for improvement in widening the scope of service.

e. Quality of Care

The quality of care was found to be excellent in thirty-six of the forty plans, (Twenty points) and to be worth fifteen points in two of them and ten points in two others, as can be seen in Table 36 on Page 292.

Plans receiving twenty points include those in which the service is normal as in private practice, because the physician is chosen and serves as a private practitioner as in cash benefit plans. Also those plans which provide research opportunities, have high standards, have extensive facilities, have well trained personnel, have few restrictions on physicians, make diagnoses early, employ preventive means, etc. deserve a rating of twenty.

Inadequate attention and cumbersome procedures reduced two of the plans to fifteen.

In one plan the physicians are overworked and underpaid and give inferior service, (Ten points) and in another malingering is encouraged by some physicians. However, as

shown above, the quality of care is generally good and is not one of the main features which must be improved to any great extent.

f. Conclusion

As can be seen from Table 37 on Page 293 six plans have received a rating of one hundred; one, ninety-five; five, ninety; fifteen, eighty-five; nine, eighty; two, seventy-five; and two, seventy. Although most of the plans received a total weight of eighty or eighty-five points, these figures do show which are the most outstanding plans.

A study of the individual features is probably more illuminating for some purposes. The six plans which were rated one hundred points each because they offer complete and good medical care to all employees either at no cost to the employee or at a moderate cost in which case the employee shares in the administration are: the proposed New York City Plan;(1) the operating plans of the Endicott-Johnson,(2) Stanocola,(3) and American Cast Iron Pipe(4) Companies; the Henry J. Kaiser Shipyards;(5) and the American Tobacco Company.(6)

The Tennessee Valley Authority Plan(7) is worth ninety-five instead of one hundred because of extra charges

(1) See Page 44
(2) See Page 194
(3) See Page 246
(4) See Page 201
(5) See Page 221
(6) See Page 199
(7) See Page 218

for dependents and incomplete service. The plans worth only seventy or seventy-five points are the medical society plans which have a small coverage, only provide obstetrics and surgery, have income limitations, and are entirely supported by the subscriber.

Further information regarding the comparative merits of the plans discussed in this thesis may be found in Table 31 on Page 268 and in the tables in Appendix I starting on Page 287. It is interesting to note, in studying these tables, that almost every type of plan may be found under each of the three ratings for each feature. This shows that one particular type of plan is not necessarily the best. Thus in evaluating the plans for a specific purpose, the most important feature must be decided and weighted accordingly. After the other features have likewise been assigned their relative weights and after adjustments have been made in the tables, the total for each plan will be more meaningful. It will still probably only show which plan is most desirable, not which type of plan. Table 38 on Page 294 summarizes the ratings of the various plans and is interesting to note.

As can be seen from the preceding table comparing the plans,(1) there is no "one best plan", but most of the plans have both desirable and undesirable features. However, certain basic features can be determined.

Michael M. Davis ably expressed the main objectives

(1) See Table 31, Pages 268, 269, and 270

of medical insurance plans when he said,

> "Medical costs must be paid for in ways that enable everybody to get medical care when they need it. Medical care must be good enough to make it worth while paying for when you get it."(1)

Both of these points are of equal importance although often the former is stressed more than the latter.

3. Health Program Conference

a. Proposals

The Health Program Conference which was mentioned above,(2) consisted of a group of twenty-nine persons including thirteen physicians, eight economists, and eight administrators. They recommended a program the principles of which would bear mentioning in brief. Their nation wide program

> "1. Would offer comprehensive service, preventive and curative.
> 2. Would provide comprehensive coverage of the population.
> 3. Would be administered with the participation of those who receive and those who furnish service, utilizing voluntary as well as governmental agencies under a National System with decentralized administration and local responsibility.
> 4. Would be supported by contributory insurance payments required by law from beneficiaries and employers, supplemented by tax funds.
> 5. Would aid localities needing hospital and public health departments to obtain or improve these facilities.
> 6. Would encourage medical service supplied through group practice and the developing of hospitals into medical service centers.

---

(1) Davis, Michael M., "Health for the Nation", Survey Graphic, Volume 33, Number 12, December, 1944, Page 491
(2) See Page 29

> 7. Would assure basic rights: patients free to choose physicians, hospitals and other medical resources including the right of group choice as well as individual choice; physicians to choose the type of practice, individual or group, which they desire; hospitals free to participate or to maintain their autonomy."(1)

This program though brief is complete and well worth discussion.

b. Evaluation

It is evident that comprehensive service is essential to the success of any medical insurance plan. In fact one of the troubles with the Blue Cross (2) is that it does not offer complete service. The importance of comprehensive coverage with no restrictions or limitations has also been emphasized in the discussion of the industrial plans and shown to be lacking particularly in plans sponsored by medical societies (3) which impose income restrictions. Participation by everyone in the financing would not necessarily mean that everyone would have to avail himself of the opportunity of utilizing the service anymore than everyone has to go to public tax-supported schools. The element of compulsion suggested here is a debatable question and no decision can rightly be reached. However, if voluntary methods are unsuccessful, compulsion may have to be resorted to. It is important that the consumer and producer (the patient and the physician) be represented on the administration,

(1) Davis, op. cit., Page 491
(2) See Page 102
(3) See Page 109

and that medical matters be under the control of doctors. As mentioned before, lack of adequate representation was found to be one of the criticisms of many of the plans discussed herein. Decentralized administration of a national program is likewise important because a large central organization such as that proposed in the Wagner-Murray-Dingell Bill (1) would find it hard to adjust to the different local conditions. Bringing medical care to local areas is necessary and probably can only be done by some sort of national action as subsidizing physicians and offering them adequate facilities. Besides reducing geographical inequalities and effecting economies, a national system would provide national standards and policies which could be adapted to local conditions and applied to functional local areas. The value of group practice has already been brought out and it was shown that research, education, experimentation, etc. are enhanced thereby. The basic rights of the physician, patient, and hospital must obviously be maintained. Thus all these principles suggested by the Health Program Conference are good. That existing voluntary agencies and their facilities should be utilized in any contemplated national plan is obvious. This conference did not bring forth any concrete suggestions as to how these aims can be accomplished which, of course, is one of the big problems today.

(1) See Page 61

4. Recommendations

a. Objectives and Needs

Most people agree as to the objectives of medical insurance plans, namely, to make complete and good medical care available to everyone at a price which can be borne by the individual and is satisfactory to the physician and under conditions satisfactory to the public and the physicians. Likewise the need for increased medical care is well known and results largely from inability to pay for available care or from lack of care. More medical and administrative personnel and additional medical facilities are needed in many areas and increased scientific research is necessary. Thus the recommendations mentioned below seem advisable.

b. Eligibility and Coverage

In establishing a new plan, industries should be careful to include as few restrictions as possible and to cover all the employees. Plans with many restrictions as to age, income, health, etc., tend to cause ill feeling instead of to accomplish their purpose. If the coverage is sufficiently wide, restrictions tend to be unnecessary actuarily. As pointed out before, the trouble with many of the plans discussed above is that the coverage is not complete. Therefore a successful program whether it be national or a combination of local plans should cover most of the population including the indigent and self-employed.

c. Administration

The problem of administration is more complicated

than it might appear on first glance. A good plan should include on the administrative board representatives of the physicians, the patients, and the general public. That there be one responsible agency in charge is another prerequisite of a good plan. Although it is not desirable to have the administration of any large plan too centralized because of local variations, it is also bad to have no central control. The happy medium must be found through experimentation. Even if voluntary methods of insurance are to continue there is no reason why the public health agencies cannot carry more of the burden of administering the health services in the future. Because of their experience, members of the public health services are better fitted to carry the responsibility of this task than any other group. Of course, this would necessitate many changes and much training but the result would be worth while. Some national program should be organized so that those not belonging to any specific group which has a medical insurance plan may be covered.

The problem of administration has been one of the most controversial subjects in recent considerations of "Medical Insurance in Industry". Those with vested interests, physicians and insurance companies, naturally do not want control taken out of their hands. It would be possible to organize a plan where this would not be necessary. Another problem of administration is that of coordinating and organizing existing health agencies so that their service can be more widely used. The best medical care requires coordinated

instead of individual practice because of the limited knowledge, equipment, and facilities of the physician practicing alone. In order for an organized group of doctors and assistant personnel with pooled equipment and use of a hospital to function effectively, a good administration must exist. Besides assuring better quality of care and more certain income for the physicians, a good administration can reduce the cost of service considerably. Freedom of choice of physician and patient should be maintained if the plan is to be acceptable to all. However, it might be necessary for the choice of physician to be made by a representative chosen by the individual. It is advisable that regardless of what type plan is adopted, use be made of existing voluntary administrative organizations. Medical societies frequently utilize the facilities of the Blue Cross. Even if a national system were established, voluntary agencies could give additional service and help administer the plan. Hospitals and physicians in medical matters should be allowed to be administratively independent, thereby dividing administration between the professional and financial fields, both of which should be coordinated through a policy determining body and advisory councils.

d. Financial Arrangements

There is no "one best way" of financing medical insurance plans although it has become increasingly evident of late that voluntary insurance alone would tend to exclude

certain economic groups. Hence, if financing through government taxes alone is objected to because it would increase taxes and be associated with dependency, perhaps the best method would be financing through insurance plans in which the employer and employee contribute varying amounts and the government supplements these contributions where necessary through general taxation. The funds collected would be used to improve facilities, extend public health departments, and help those not covered by insurance and would be collected nationally. Of course, this method would not be easy to institute because of the different requirements of the various parts of the country, but it is possible especially, if the taxation is a local matter. Adequate pay to physicians must be allowed for in the making of a financial budget as should provisions for the improvement of facilities. It is interesting to note that at the present time, tax supported service is offered at no charge to members of the armed forces, veterans, dependent people, and persons with mental diseases and tuberculosis as are public health and preventive services.

e. Scope of Service

The aim of all plans should be to provide comprehensive and complete service to everyone including services of general practitioners and specialists wherever needed, hospital and nursing care, dental service, medicines and appliances, laboratory and diagnostic services, etc. Of course

this is more easily said than done and cannot be done at once because of the unequal distribution of finances, facilities, and personnel. Nevertheless the aim can be accomplished gradually. Too often preventive services as periodic examinations, special provisions for tuberculosis, maternity care, control of communicable diseases, etc. are neglected in medical insurance plans. Thus a good plan should include community and individual health prevention and cure and also provide a minimum income for ordinary expenses during periods of disability.

f. Quality of Care

One factor which influences the quality of the care perhaps more than any other is the physician. It goes without saying that the administrators of a plan should endeavor to secure the services of qualified medical experts and that there should be standards of education, experience, and ability. There should also be provisions for postgraduate education and training of these physicians in teaching hospitals, assurance of adequate annual income, and opportunities for research commensurate with skill, experience, and responsibility.

Also adequate physical facilities including hospitals, modern equipment, health centers, etc. should be provided and made available to all physicians, from public funds if necessary. One reason why more physicians do not practice in rural areas is the lack of good local diagnostic and hospital facilities in these places. Opportunities for increased research should also be available. The quality of

the service is often improved by group practice as that in hospitals, clinics, and medical service centers, because the advice and opinions of fellow physicians is easily obtainable. If necessary

> "Legislation and administration should be designed to maintain, promote, and extend a high quality of medical care especially in those areas and those kinds of medical service which need improvement."(1)

Health education would also tend to improve the quality of care.

g. Conclusions

It would be almost impossible to develop a plan which would completely satisfy all the producers, consumers, sponsors, and publically minded citizens. All the plans discussed in this thesis have their good and bad points and no one of them is "the best plan". It is hoped that the material assembled in this thesis will be of some use to those planning to institute new medical insurance plans. As mentioned before, by studying the table "Comparison of Forty Weighted Plans by Types and Qualities"(2) the expert by attaching different weights to the various features can determine what type plan will best fit his needs. It was not the purpose of this thesis to predict the future of medical insurance or to suggest one particular plan as the best.

---

(1) Committee on Research in Medical Economics, "Principles of a Nationwide Health Program", New York, November, 1944, Page 6

(2) See Pages 268, 269, and 270

However, a plan which would perhaps come nearer to achieving the goal of complete medical coverage and which would pacify those with vested interests would probably be one that compels everyone to be insured by some plan and which provides through taxation the means to accomplish this objective in areas where no voluntary plans exist. There will probably be some major changes in the near future in the field of "Medical Insurance in Industry" and it is hoped that this thesis has contributed its bit toward the collection of facts on which future decisions can be based.

APPENDIX I

ORIGINAL TABLES

(See List of Tables on Page XII)

TABLE 32

Eligibility and Coverage of Forty Weighted Plans

Plan	Type	Wgt	Reason
New York City	Voluntary Local Government (Proposed)	20	No restrictions--everyone in city eligible
Wagner-Murray-Dingell Bill	Compulsory Federal Government (Proposed)	20	No restrictions--everyone in country eligible.
Denmark	Voluntary National	20	No restrictions--Everyone in country eligible
Russia	Compulsory National	20	No restrictions--Everyone in country eligible
New Zealand	Compulsory National	20	No restrictions--everyone in country eligible
International Ladies' Garment Workers'	Union	20	All members eligible
International Workers Order	Union	20	No restrictions--all employees eligible
Insurance Companies	Commercial Insurance Companies	20	No restrictions--all members of group eligible
The Prudential Insurance Company of America	Commercial Insurance Company	20	No restrictions--all members of group eligible
Tampa, Florida	Cooperative	20	No restrictions--all members of group eligible
Endicott Johnson Company	Non-Contributory Medical Service	20	No restrictions--all employees of group eligible
Paraffine Company	Non-Contributory Medical Service	20	No restrictions--all employees of group eligible
American Tobacco Co. and American Supplies Inc.	Non-Contributory Medical Service	20	No restrictions--all employees eligible
American Cast Iron Pipe Company	Non-Contributory Medical Service	20	No restrictions--all employees eligible
Batchelder and Snyder Co. Inc.	Joint Employer-Employee Cash Benefit	20	No restrictions--all employees eligible
General Electric	Joint Employer-Employee Cash Benefit	20	No restrictions--all employees eligible
Tennessee Coal, Iron, and Railroad Co.	Joint Employer-Employee Medical Service	20	No restrictions--all employees eligible
Tennessee Valley Authority	Joint Employer-Employee Medical Service	20	No restrictions--all employees eligible
Henry J. Kaiser Shipyards (N. Permanente Foundation)	Joint Employer-Employee Medical Service	20	No restrictions--all employees eligible
William Filenes Sons Co.	Employee Cash Benefit	20	No restrictions--all employees eligible
American Bosch Company	Employee Cash Benefit	20	No restrictions--all employees eligible
Stanocola	Employee Medical Service	20	No restrictions--all employees eligible
Rhode Island State	Compulsory State Government	15	Waiting period
The Model Bill	Voluntary State Government (Proposed)	15	Occupational and service restrictions
Germany	Compulsory National	15	Occupational restrictions
Great Britain	Compulsory National	15	Dependents not included
France	Compulsory National	15	Income restrictions
Blue Cross	Voluntary Non-Profit Private Association	15	Income restrictions. Increasing coverage. Still relatively small.
Michigan Mutual Health Service	Medical Society	15	Few subscribers--more than other medical society plans
Ross-Loos Clinic	Rrivate Group Clinic	15	Only those between 21 and 50 are eligible
Boston Edison	Non-Contributory Cash, Hospital and Surgical Benefits	15	One year waiting period
Dunn and McCarthy Shoe Factory Binghampton, New York	Joint Employer-Employee Medical Service	15	Waiting period
Consolidated Edison of New York	Joint Employer-Employee Medical Service	15	Dependents not included
Lynn Riverworks of General Electric	Employee Cash Benefit	15	Recommendation necessary
California Physicians'	Medical Society	10	Income limitations--few subscribers
Massachusetts Blue Shield	Medical Society	10	Income limitations--few subscribers
New Jersey Medical Surgery Plan	Medical Society	10	Restricted to those enrolled in hospital plans. Few subscribers
Cafeteria Employees Union	Union	10	Only those between 18 and 50 are eligible. Waiting period, physical exam required.
New England Telephone and Telegraph	Non-Contributory Cash Benefit	10	Two year waiting period
Colonial Beacon Hospital and Medical Association Inc.	Employee Medical Service	10	Too restrictive, waiting period, age requirements, physical examinations.

Table 33

Administration of Forty Weighted Plans

Plan	Type	Wgt	Reason
New York City	Voluntary Local Government (Proposed)	20	Physicians and subscribers represented.
Great Britain	Compulsory National	20	Physicians and subscribers represented.
Massachusetts Blue Shield	Medical Society	20	Physicians, subscribers, and general public represented.
International Ladies' Garment Workers' Union	Union	20	Administered by consumer's representatives
Cafeteria Employees	Union	20	Administered by subscribers
International Workers Order	Union	20	Representative administration. Consumer sponsored.
Tampa, Florida	Cooperative	20	Members represented.
New England Telephone and Telegraph	Non-Contributory Cash Benefit	20	Employees pay nothing so need not be represented.
Endicott Johnson	Non-Contributory Medical Service	20	Employees pay nothing so need not be represented.
Paraffine Company	Non-Contributory Medical Service	20	Employees pay nothing so need not be represented.
American Tobacco and American Supplies Inc.	Non-Contributory Medical Service	20	Employees pay nothing so need not be represented
American Cast Iron Pipe Company	Non-Contributory Medical Service	20	Employees pay nothing so need not be represented
Tennessee Valley Authority	Joint Employer-Employee Medical Service	20	Subscribers are represented in a mutual benefit association
Henry J. Kaiser Shipyards	Joint Employer-Employee Medical Service	20	Physician and subscriber represented
Dunn and McCarthy Shoe Factory, Binghampton, New York	Joint Employer-Employee Medical Service	20	Mutual benefit society
Standard Oil Company of Louisiana (Stanocola)	Employee Medical Service	20	Subscribers plus physicians are represented
Consolidated Edison of New York	Joint Employer-Employee Medical Service	20	Subscribers administer through mutual benefit society. Medical service is under doctors.
Colonial Beacon Employees Hospital Medical Association	Employee Medical Service	20	Administered by employee association
William Filene's Sons Company	Employee Cash Benefit	20	Subscribers administer
Lynn Riverworks of General Electric	Employee Cash Benefit	20	Subscribers are represented in a mutual benefit association
American Bosch Company	Employee Cash Benefit	20	Administered by employee association
Rhode Island State	Compulsory State Government	15	Subscribers not represented
Denmark	Voluntary National	15	Subscribers not represented
France	Compulsory National	15	Societies and Doctors administer with confusion
New Zealand	Compulsory National	15	Administered by Ministry of Health. Doctors not controlled.
Blue Cross	Voluntary Non-Profit Private Association	15	Subscriber not represented
Michigan Mutual Health Service	Medical Society	15	Subscriber not represented. Controlled by physicians
California Physicians	Medical Society	15	Subscriber not represented. Controlled by physicians.
New Jersey Surgical	Medical Society	15	Subscriber not represented. Controlled by physicians.
Ross-Loos Clinic	Private Group Clinic	15	Subscriber not represented.
Boston Edison Company	Non-Contributory, Hospitalization, and Surgical Benefit	15	Subscriber not represented though pays for dependents.
Batchelder and Snyder Company	Joint Employer-Employee Cash Benefit	15	Subscriber not represented though pays for dependents and self
General Electric	Joint Employer-Employee Cash Benefit	15	Subscriber not represented though pays for dependents plus self
The Model Bill	Voluntary State Government (Proposed)	10	Physicians and subscribers not represented.
Wagner-Murray-Dingell Bill	Compulsory Federal Government (Proposed)	10	Too much power in Surgeon General's hands
Germany	Compulsory National	10	Too bureaucratic
Russia	Compulsory National	10	Completely comtrolled by government
Insurance Companies	Commercial Insurance Companies	10	Completely in hands of company and impersonal
Prudential Life Insurance Company of America	Commercial Insurance Company	10	Completely in hands of company and impersonal
Tennessee Coal, Iron, and Railroad Company	Joint Employer-Employee Medical Service	10	Physician and subscriber not represented--administered by company

TABLE 34

Financial Arrangements of Forty Weighted Plans

Plan	Type	Wgt	Reason
New York City	Voluntary Local Government (Proposed)	20	Employer and employee share
Rhode Island State	Compulsory State Government (Proposed)	20	Employer and employee share
The Model Bill	Voluntary State Government (Proposed)	20	State, employer, and employee share
Denmark	Voluntary National	20	State, employer, and employee share
Germany	Compulsory National	20	State, employer, and employee share
Great Britain	Compulsory National	20	State, employer, and employee share
France	Compulsory National	20	State, employer, and employee share
Russia	Compulsory National	20	State finances
Tampa, Florida	Cooperative	20	Financed by members' dues
International Ladies' Garment Workers'	Union	20	Financed by union dues
Cafeteria Employees	Union	20	Small fees
Insurance Companies	Commercial Insurance Companies	20	Employer and employee share
Prudential Insurance Company of America	Commercial Insurance Company	20	Employer and employee share
New England Telephone and Telegraph Co.	Non-Contributory Cash Benefit	20	Employer pays all
Boston Edison Company	Non-Contributory Cash Benefit	20	Employer pays for employee who pays for dependents
Endicott Johnson Co.	Non-Contributory Medical Service	20	Employer pays all
Paraffine Company	Non-Contributory Medical Service	20	Company pays all
American Tobacco and American Supplies Inc.	Non-Contributory Medical Service	20	Company pays all
American Cast Iron Pipe Company	Non-Contributory Medical Service	20	Employer pays all
Tennessee Coal, Iron, and Rail-Road Company	Joint Employer-Employee Medical Service	20	Employer and employee share
Tennessee Valley Authority	Joint Employer-Employee Medical Service	20	Employer and employee share
Henry J. Kaiser Shipyards	Joint Employer-Employee Medical Service	20	Employer and employee share
Consolidated Edison	Joint Employer-Employee Medical Service	20	Employer and employee share
Dunn and McCarthy Shoe Factory, Binghampton, New York	Joint Employer-Employee Medical Service	20	Employer and employee share
William Filene's Sons Company	Employee Cash Benefit	20	Employee pays most. Helped by employer.
Stanocola	Employee Medical Service	20	Employee pays most. Helped by employers.
Wagner-Murray-Dingell Bill	Compulsory Federal Government (Proposed)	15	State, employer, and employee share. Charges too high.
New Zealand	Compulsory National	15	State, employer, and employee share. Charges too high.
Blue Cross	Voluntary non-profit, private association.	15	Burden entirely on subscriber.
Michigan Mutual Health Service	Medical Society	15	Burden entirely on subscriber
California Physicians	Medical Society	15	Burden entirely on subscriber
Massachusetts Blue Shield	Medical Society	15	Burden entirely on subscriber
New Jersey Medical Surgical	Medical Society	15	Burden entirely on subscriber
Ross-Loos Clinic	Private Group Clinic	15	Charges too high
International Workers Order	Union	15	Too many extra charges
Batchelder and Snyder Company	Joint Employer-Employee Cash Benefit	15	Employer and employee share. Charges high for services rendered.
General Electric Company	Joint Employer-Employee Cash Benefit	15	Employer and employee share. Charges high for services rendered.
Lynn Riverworks of General Electric	Employee Cash Benefit	15	Burden entirely on subscriber
American Bosch Mutual Benefit Association	Employee Cash Benefit	15	Burden entirely on subscriber
Colonial Beacon Employees' Hospital and Medical Association	Employee Medical Service	15	Burden entirely on subscriber

TABLE 35

Scope of Service of Forty Weighted Plans

Plan	Type	Wgt	Reason
New York City	Voluntary Local Government (Proposed)	20	Completa medical service
The Model Bill	Voluntary State Government (Proposed)	20	Complete medical service
Wagner-Murray-Dingell Bill	Compulsory Federal Government (Proposed)	20	Complete medical service
Germany	Compulsory National	20	Complete medical service
Russia	Compulsory National	20	Complete medical service
Ross-Loos Clinic	Private Group Clinic	20	Complete medical service
Endicott Johnson Company	Non-Contributory Medical Service	20	Complete medical service
American Cast Iron Pipe Company	Non-Contributory Medical Service	20	Complete medical service
American Tobacco and American Supplies Inc.	Non-Contributory Medical Service	20	Complete medical service
Henry J. Kaiser Shipyards (N. Permanente Foundation)	Joint Employer-Employee Medical Service	20	Complete medical service
Colonial Beacon Employees Hospital and Medical Association	Employee Medical Service	20	Complete medical service
Stanocola	Employee Medical Service	20	Complete medical service
Great Britain	Compulsory National	15	No specialist care, lab care, or dental care
France	Compulsory National	15	Limited to cash first two years
New Zealand	Compulsory National	15	Not complete medical service
Denmark	Voluntary National	15	Limited service
Blue Cross	Voluntary Non-Profit Private Association	15	Does not provide service of physician outside hospital
Tampa, Florida	Cooperative	15	Not complete medical service
Cafeteria Employees'	Union	15	Limited service
Boston Edison Company	Non-Contributory Cash, Hospitalization, and Surgical Benefits	15	Provides hospitalization and surgical benefita and cash but not complete medical service.
Tennessee Coal, Iron, and Railroad Company	Joint Employer-Employee Medical Service	15	Extra charges for hospital and specialist service. Not complete medical service.
Tennessee Valley Authority	Joint Employer-Employee Medical Service	15	Extra charges for dependents--not complete medical service.
Consolidated Edison of New York	Joint Employer-Employee Medical Service	15	Does not include hospitalization
Dunn and McCarthy Shoe Factory, Binghampton, New York	Joint Employer-Employee Medical Service	15	Not complete medical servica
Rhode Island State	Compulsory State Government	10	Only cash benefit for wages lost
Michigan Mutual Health Service	Medical Society	10	Limited to surgery and obstetrics
California Physicians' Plan	Medical Society	10	Limited to surgery and ohstetrics
Massachusetts Blue Shield	Medical Society	10	Limited to surgery and obstetrics
New Jersey Medical Surgical	Medical Society	10	Limited to surgery and obstetrics
International Ladies' Garment Workers' Union	Union	10	Limited medical service--hospitalization and operations excluded
International Workers' Order	Union	10	Service too limited
Insurance Companies	Commercial Insurance Companies	10	Cash Benefit only
The Prudential Life Insurance Company of America	Commercial Insurance Company	10	Caah Benefits only. Does not includa money for medical care outside of hospital
New England Telephone and Telegraph Company	Non-Contributory Cash Benefit	10	Limited to cash and minor treatment
Paraffine Company	Non-Contributory Medical Service	10	Limited to general practitioner care
Batchelder and Snyder	Joint Employer-Employee Cash Benefit	10	Cash benefits only
General Electric Company	Joint Employer-Employee Cash Benafit	10	Cash benefita only
Lynn Riverworks of General Electric	Employee Cash Benefit	10	Cash benefits only
William Filene's Sons Company	Employee Cash Benefit	10	Cash benefits only. Too many restrictions
American Bosch Company	Employee Cash Benefit	10	Cash benefita too little

TABLE 36

Quality of Care of Forty Weighted Plans

Plan	Type	Wgt.	Reason
New York City	Voluntary Local Government (Proposed)	20	Medical research and board of standards.
Rhode Island State	Compulsory State Government	20	Normal as in private practice.
The Model Bill	Voluntary State Government (Proposed)	20	Normal as in private practice.
Wagner-Murray-Dingell Bill	Compulsory Federal Government (Proposed)	20	Extensive facilities and good medical standards.
Denmark	Voluntary National	20	Normal as in private practice.
Germany	Compulsory National	20	Adequate facilities and personnel.
France	Compulsory National	20	Doctors not restricted
Russia	Compulsory National	20	Modern hospital and government standards.
New Zealand	Compulsory National	20	Doctors not restricted.
Blue Cross	Voluntary Non-Profit Private Association	20	Excellent care in hospitals by staff physicians.
Michigan Mutual Health Service	Medical Society	20	Service offered by qualified physicians.
California Physicians	Medical Society	20	Service offered by qualified physicians.
Massachusetts Blue Shield	Medical Society	20	Service offered by qualified physicians.
New Jersey Medical Surgical	Medical Society	20	Service offered by qualified physicians.
Ross-Loos Clinic	Private Group Clinic	20	Good staff.
Cafeteria Employees	Union	20	Good staff.
International Workers Order	Union	20	Good staff
Insurance Companies	Commercial Insurance Companies	20	Normal as in private practice.
The Prudential Insurance Company of America	Commercial Insurance Company	20	Normal as in private practice.
New England Telephone and Telegraph Company	Non-Contributory Cash Benefit.	20	Normal as in private practice. Good first aid.
Boston Edison Company	Noh-Contribitory Cash, Hospitalization, and Surgical Benefits	20	Normal as in private practice.
Endicott-Johnson Company	Non-Contributory Medical Service	20	Picked staff. complete facilities.
Paraffine Company	Non-Contributory Medical Service	20	Good staff.
American Tobacco and American Supplies Inc.	Non-Contributory Medical Service	20	Good staff.
American Cast Iron Pipe Company	Non-Contributory Medical Service	20	Preventive services.
Batchelder and Snyder Company Inc.	Joint Employer-Employee Cash Benefit	20	Normal as in private practice.
Tennessee Coal, Iron, and Railroad Company	Joint Employer-Employee Medical Service	20	Good facilities and personnel.
Tennessee Valley Authority	Joint Employer-Employee Medical Service	20	Well trained personnel and adequate facilities.
Henry J. Kaiser (Northern Permanente Foundation)	Joint Employer-Employee Medical Service	20	Excellent facilities and staff.
Consolidated Edison of New York	Joint Employer-Employee Medical Service	20	Normal as in private practice.
Dunn and McCarthy Shoe Factory, Binghampton, New York	Joint Employer-Employee Medical Service	20	Normal as in private practice.
American Bosch Company	Employee Cash Benefit	20	Normal as in private practice.
General Electric Company	Employee Cash Benefit	20	Normal as in private practice.
Lynn Riverworks of General Electric	Employee Cash Benefit	20	Normal as in private practice.
Colonial Beacon Employees' Hospital and Medical Association Inc.	Employee Medical Service	20	Normal as in private practice.
Stanocola	Employee Medical Service	20	Excellent facilities, early diagnosis, group cooperation
Great Britain	Compulsory National	15	Panel system, inadequate attention.
International Ladies' Garment Workers'	Union	15	Cumbersome procedure.
Tampa, Florida	Cooperative	10	Inferior, overworked, underpaid physicians.
William Filene's Sons Company	Employee Cash Benefit	10	Cumbersome, malingering.

TABLE 37

Total Weights of Forty Plans

Plan	Type	Wgt	Remarks
New York City	Voluntary Local Government (Proposed)	100	Complete service, cost shared by employer and employee.
Endicott-Johnson Company	Non-Contributory Medical Service	100	Complete service at no cost to employee.
American Tobacco Company and American Supplies Inc.	Non-Contributory Medical Service	100	Complete Medical care free.
American Cast Iron Pipe Company	Non-Contributory Medical Service	100	Complete service at no cost to employee
Henry J. Kaiser Shipyards (Northern Permanente Foundation)	Joint Employer-Employee Medical Service	100	Complete service. Cost shared by employer and employee.
Stanocola	Employee Medical Service	100	Complete service. Cost shared by employer and employee
Tennessee Valley Authority	Joint Employer-Employee Medical Service	95	Extra charge for dependents. Service not complete.
Denmark	Voluntary National	90	Subscribers not represented. Limited service.
Russia	Compulsory National	90	Complete service free controlled by government
Paraffine Company	Non-contributory Medical Service	90	Service limited to general practitioner care
Consolidated Edison of New York	Joint Employer-Employee Medical Service	90	Does not include family members or hospitalization.
Dunn and McCarthy Shoe Factory, Binghampton, New York	Joint Employer-Employee Medical Service	90	Eligibility restricted. Service not complete.
The Model Bill	Voluntary State Government (Proposed)	85	Not representative. Too restrictive.
Wagner-Murray-Dingell Bill	Compulsory Federal Government (Proposed)	85	Too much central control.
Germany	Compulsory National	85	Too bureaucratic
Great Britain	Compulsory National	85	Good administration. Coverage and service should be extended.
France	Compulsory National	85	Income restrictions. Limited service
New Zealand	Compulsory National	85	High charges and non representative administration
Tampa, Florida	Cooperative	85	Poor quality and incomplete service
Ross-Loos Clinic	Private Group Clinic	85	Limited eligibility and service. Non representative administration.
International Ladies' Garment Workers'	Union	85	Administered by consumer. Limited service.
Cafeteria Employees	Union	85	Limited eligibility. Poor and limited service.
Boston Edison Co.	Non-Contributory Cash Benefit, Hospital and Surgical Benefits	85	Should offer more medical service and shorter waiting period
Tennessee Coal, Iron, and Railroad Company	Joint Employer-Employee Medical Service	85	Company administers though employee shares cost and pays extra for dependents
American Bosch Company	Employee Cash Benefit	85	Employee pays all benefit. Too small.
Colonial Beacon Employees Hospital and Medical Association Inc.	Employee Medical Service	85	Eligibility restrictions and employee finances.
Rhode Island State	Compulsory State Government	80	Cash benefit only. Subscriber not represented. Only active state compulsory medical insurance plan in the United States.
Blue Cross	Voluntary Non-Profit Private Association	80	Coverage increasing. Provides care in hospitals only. Financial burden on non-represented subscribers.
International Workers Order	Union	80	Too many extra charges. Too limited service.
Insurance Companies	Commercial Insurance Companies	80	Cash benefit only. Subscriber not represented.
The Prudential Life Insurance Company of America	Commercial	80	Cash benefit only. Subscriber not represented.
New England Telephone and Telegraph Company	Non-Contributory	80	Free. Limited service Long waiting period
Batchelder and Snyder Company	Joint Employer-Employee Cash Benefit	80	Only cash benefit High charges
General Electric Company	Joint Employer-Employee Cash Benefit	80	Only cash benefit. High charges.
Lynn Riverworks of General Electric	Employee Cash Benefit	80	Only cash benefit. Employees administer and support.
William Filene's Sons Company	Employee Cash Benefit	80	Only cash benefit. Too much malingering
Michigan Mutual Health Service	Medical Service	75	Small coverage although more than other medical societies. Only surgery and obstetrics. Financial burden entirely on subscriber though administered by physician.
Massachusetts Blue Shield	Medical Society	75	Income and service limitations. Small coverage. Representative administration, Financial burden entirely on subscriber.
California Physicians	Medical Society	70	Income and service limitations. Financial burden on non-represented subscriber. Small coverage.
New Jersey Medical Surgical	Medical Society	70	Restricted to those enrolled in hospital plan. Limited service. Financial burden on non-represented subscribers. Small coverage.

TABLE 38

Summary of Weights of Forty Plans

Feature and Points	Number of Plans
Eligibility and Coverage	
20 points	22
15 points	12
10 points	6
	40
Administration	
20 points	21
15 points	12
10 points	7
	40
Financial Arrangements	
20 points	26
15 points	14
10 points	0
	40
Scope of Service	
20 points	12
15 points	12
10 points	16
	40
Quality of Care	
20 points	36
15 points	2
10 points	2
	40
Total Weights	
100 points	6
95 points	1
90 points	5
85 points	15
80 points	9
75 points	2
70 points	2
	40

APPENDIX II

Sample Forms of the
NEW ENGLAND TELEPHONE AND TELEGRAPH COMPANY

(See List of Sample Forms on Page XIV)

MEDICAL DEPARTMENT

APPLICANT MEDICAL RECOMMENDATION AND RATING

(Name)..an applicant for employment has submitted to medical examination and is:

Recommended for the position specified as..........Class..........

Recommended for employment as..........Class..........

Deferred from employment..........Class "D"..........

Not Recommended for employment..........Class "R"..........

Explanation of Medical Rating..........

Dated.......... By..........
Medical Director

Title..........

If engaged for employment, I agree to undertake proper treatment to overcome the above reported impairment within the allotted time.

Signed..........
(Applicant)

MEDICAL HISTORY

#2 MALE APPLICANT EMPLOYEE

NEW ENGLAND TEL. & TEL. CO.

AME	DATE OF BIRTH	BIRTHPLACE	REFERRED BY
DDRESS	CONJUGAL STATE S M W D	NO. OF CHILDREN L D	TITLE LOCATION

CCUPATION
PRESENT
PREVIOUS (FOR 3 YEARS)
PROPOSED

AMILY HISTORY (WITH PARTICULAR REFERENCE TO INSANITY, EPILEPSY, EXPOSURE TO TUBERCULOSIS)

RE YOUR WIFE AND ALL CHILDREN LIVING AND WELL? IF NOT EXPLAIN

HAT DISEASES HAVE YOU HAD? (WITH PARTICULAR REFERENCE TO RHEUMATISM, LUMBAGO, TONSILLITIS, PLEURISY AND DISEASE OF THE LUNGS.) OF EACH ILLNESS GIVE AGE AT TIME, URATION AND RESULT:-

AVE YOU EVER HAD?
ERNIA
FISTULA OR HEMORRHOIDS
ABSCESSED OR DISCHARGING EARS
FAINTING SPELLS
SPITTING OF BLOOD
VENEREAL DISEASE

HAT INJURIES HAVE YOU HAD? (OF EACH GIVE ANATOMICAL LOCATION, DATE, DURATION OF DISABILITY AND RESULT):-

HAT SURGICAL OPERATIONS HAVE YOU HAD? (OF EACH GIVE ANATOMICAL LOCATION, DATE, DURATION OF DISABILITY AND RESULT):-

OW MUCH TOBACCO DO YOU USE, AND IN WHAT FORM?

DO YOU WEAR GLASSES?

RE YOU RECEIVING ANY PENSION OR DISABILITY COMPENSATION? EXPLAIN

SIGNATURE OF APPLICANT

MEDICAL HISTORY RECORD

NEW ENGLAND TEL. & TEL. CO.

FEMALE

(CHECK ONE)
APPLICANT
TEMPORARY EMPLOYEE
REGULAR EMPLOYEE

NAME ____ MAIDEN NAME ____ BIRTHPLACE ____ REFERRED BY

#3

ADDRESS ____ CONJUGAL STATE S M W D ____ DATE OF BIRTH ____

TITLE

HUSBAND LIVING ____ HEALTH ____ DEAD ____ DATE ____ REASON ____

NO. CHILDREN LIVING ____ AGE OF YOUNGEST CHILD ____ NO. DEAD ____ REASON ____

LOCATION

OCCUPATIONAL

PREVIOUS WITH TELEPHONE CO. FROM ____ TO ____ SERVICE ENDED BECAUSE OF ____

OCCUPATIONS IN LAST 2 YEARS ____ FINISHED SCHOOL ____

NOW APPLYING FOR POSITION AS ____

FAMILY HISTORY	TUBERCULOSIS	DIABETES	EPILEPSY	INSANITY	OTHER

PREVIOUS ACCIDENTS, ILLNESSES OR OPERATIONS

EVER CONFINED TO SANATORIUM OR OTHER HOSPITAL ____

ANY TUBERCULOSIS IN YOUR HOUSE IN PAST 5 YRS. ____

ARE UTERINE FUNCTIONS NOW REGULAR ____

DO YOU HAVE OR HAVE YOU EVER HAD DISEASE OR TUMOR OF

BREASTS ____ OVARY ____ UTERUS ____

ANY WEIGHT CHANGE PAST 2 YRS. ____ REASON ____

DO YOU HAVE OR HAVE YOU EVER HAD

HAY FEVER OR ASTHMA ____

SKIN RASH ____

CONVULSIONS ____

FAINTING ATTACKS ____

NERVOUS BREAKDOWN ____

PAINFUL MENSTRUATION ____

ANY LOSS OF TIME

DESCRIBE ANY POSITIVE HISTORY ABOVE, OR ADDITIONAL INFORMATION

ARE YOU NOW IN GOOD HEALTH ____

SIGNATURE OF EXAMINED PERSON

NEW ENG. TEL. & TEL. CO.
DINING SERVICE

NAME ____ DATE ____

DO YOU CONSIDER YOURSELF TO BE IN GOOD HEALTH AT THE PRESENT TIME? ____

#4

WHAT ILLNESSES OR OPERATIONS HAVE YOU HAD IN THE PAST TWO YEARS? ____

CATAMENIA ____

GENITO-URINARY ____

DO YOU HAVE:—

HEADACHES ____

DIZZINESS ____

EYE TROUBLE ____

EARACHE OR DISCHARGE ____

TOOTH-ACHES ____

SORE THROATS ____

RHEUMATISM ____

SORE MOUTH OR TONGUE ____

COUGH OR SPUTUM ____

PAIN IN THE CHEST ____

SHORTNESS OF BREATH ____

SWELLING OF ANKLES ____

INDIGESTION ____

CONSTIPATION ____

DIARRHEA ____

PILES ____

VAGINAL DISCHARGE ____

ANY PRESENT LUMPS IN BREASTS ____
OR
ELSEWHERE ____
OR
HAVE YOU EVER HAD ANY ____

EXAMINING PHYSICIAN SHOULD DESCRIBE IN DETAIL ANY POSITIVE HISTORY OR OTHER INFORMATION:—

#5

NAME:— BIRTH:— SERVICE BEGAN:— POSITION:—

DATE	DIAGNOSIS REFERS TO NEW CONDITIONS AND NOT TO REVISITS FOR SAME CONDITION	CHECK ✓ IF DISABLED

X-RAY EXAMINATIONS

DATE	REGION EXAMINED	POS. OR NEG.

SPUTUM

DATE	FINDINGS

TUBERCULOSIS

#6

Name ______ Case # ______ Dept. ______ Job ______

Address ______ Location ______

Date of Birth ______ Sex ______ Marital State ______

DIAGNOSIS

Absence Began ______ Paid Days Lost ______ Amt. Ben. Pd. ______

Absence Terminated ______ Furlough Days ______

or

Age Absence Began ______ Disability Pension ______ to ______ Amount Paid ______

Length of Service ______ Total Days Lost ______ Total Amount Paid ______

FAMILY AND PAST HISTORY

Pre-Employment Exam. ______ Examiner ______

Rating ______ Reason (if not Class "A") ______

Other cases in family ______

TREATMENT

Home ______ Physician ______

Sanatorium ______ Name ______

Rest ______ Pneumothorax ______ Surgery ______

Other ______

FINAL DISPOSAL

Return to Work (arrested) ______

Released ______

Reason ______

Deceased ______

(OVER)

1-1-43

DEATH RECORD

#7

NAME ______ LAST ______ FIRST ______ MIDDLE ______ DEPT. ______ DIV. ______ DATE OF DEATH ______

BUS. ADDRESS ______ OCCUP. ______ AGE AT DEATH ______ YRS. MOS. DAYS

IMMEDIATE CAUSE OF DEATH ______ (PLEASE NOTE IF ACCIDENT OR SUICIDE) SERV. AT DEATH ______ YRS. MOS. DAYS

CONTRIBUTING CAUSE OF DEATH ______

ACTIVE EMPLOYEE

DATE ABSENCE BEGAN ______

AGE AT DATE ABSENCE BEGAN ______ YRS. MOS. DAYS

SERVICE AT DATE ABSENCE BEGAN ______ YRS. MOS. DAYS

(CHECK ONE)
HEALTH AT DATE ABSENCE BEGAN

- -UNSATISFACTORY ☐
- -APPARENTLY GOOD ☐
- -NO RECORD ☐

(CHECK ONE)
DEATH OCCURRED

- -WHILE AT WORK ☐
- -WITHIN 24 HRS. OF WORK ☐
- -AFTER ABSENCE OF 1 DAY OR MORE ☐

RETIRED EMPLOYEE

DATE PENSION BEGAN ______ CLASS OF PENSION ______

AGE AT DATE PENSION BEGAN ______ YRS. MOS. DAYS

SERVICE AT DATE PENSION BEGAN ______ YRS. MOS. DAYS

(CHECK ONE)
HEALTH AT DATE PENSION BEGAN

- -UNSATISFACTORY ☐
- -APPARENTLY GOOD ☐
- -NO RECORD ☐

DURATION OF PENSION

______ YRS. MOS. DAYS

REMARKS: ______

SIGNED ______ M. D.

New England Telephone and Telegraph Co.

MEDICAL DEPARTMENT X-Ray Record

File No. #8

Patient's Name Age S. M. W. D.

Occupation, Department, Location.

Date	Film No.	Region Examined	Technician	Remarks

FILING EQUIPMENT BUREAU H6788

#9

EQUIPMENT INSTALLER—Inside work. May require some heavy lifting, stooping and bending, working away from home, requires good bilateral vision, good hearing, normal color sense, working aloft up to ten feet or so.

POWERMAN—Requires operation of electric or gas engine power-plant and moving machinery and work in storage battery rooms.

TESTMAN—Inside work similar to desk work. Requires nervous stability, good hearing.

LINE ASSIGNER—Inside desk work, mostly clerical.

INSPECTOR—Outside work. May require much walking.

COLLECTOR—Outside work, requires driving truck, visits to business establishments and private homes, contact with public. May require lifting of coin boxes weighing up to fifty-five pounds and to use stairways.

WIRE CHIEFS, FLOOR SWITCHMEN, FOREMEN, MANAGERS, SUPERVISORS, ETC., are occupations of a supervisory nature, require little or no physical exertion but poise, nervous stability and good judgment.

TELEPHONE OPERATORS AND SUPERVISORS—INSIDE WORK. Requires good bilateral hearing and vision, normal function of fingers, hands, arms and shoulders, freedom from backache.

COMMERCIAL REPRESENTATIVES—Inside desk work and requires meeting the public.

EMPLOYEES CERTIFICATION FOR PAYMENT #11

FIRST SEVEN DAYS OF ABSENCE DUE TO ILLNESS

This is to certify that I was absent from work on .... (date)

to .... (date) inclusive by reason of .... (State nature of illness)

Payment for this absence is requested in accordance with the terms of General Order Number 2.

Approved ....

Title .... Date ....

Paid week ending ....

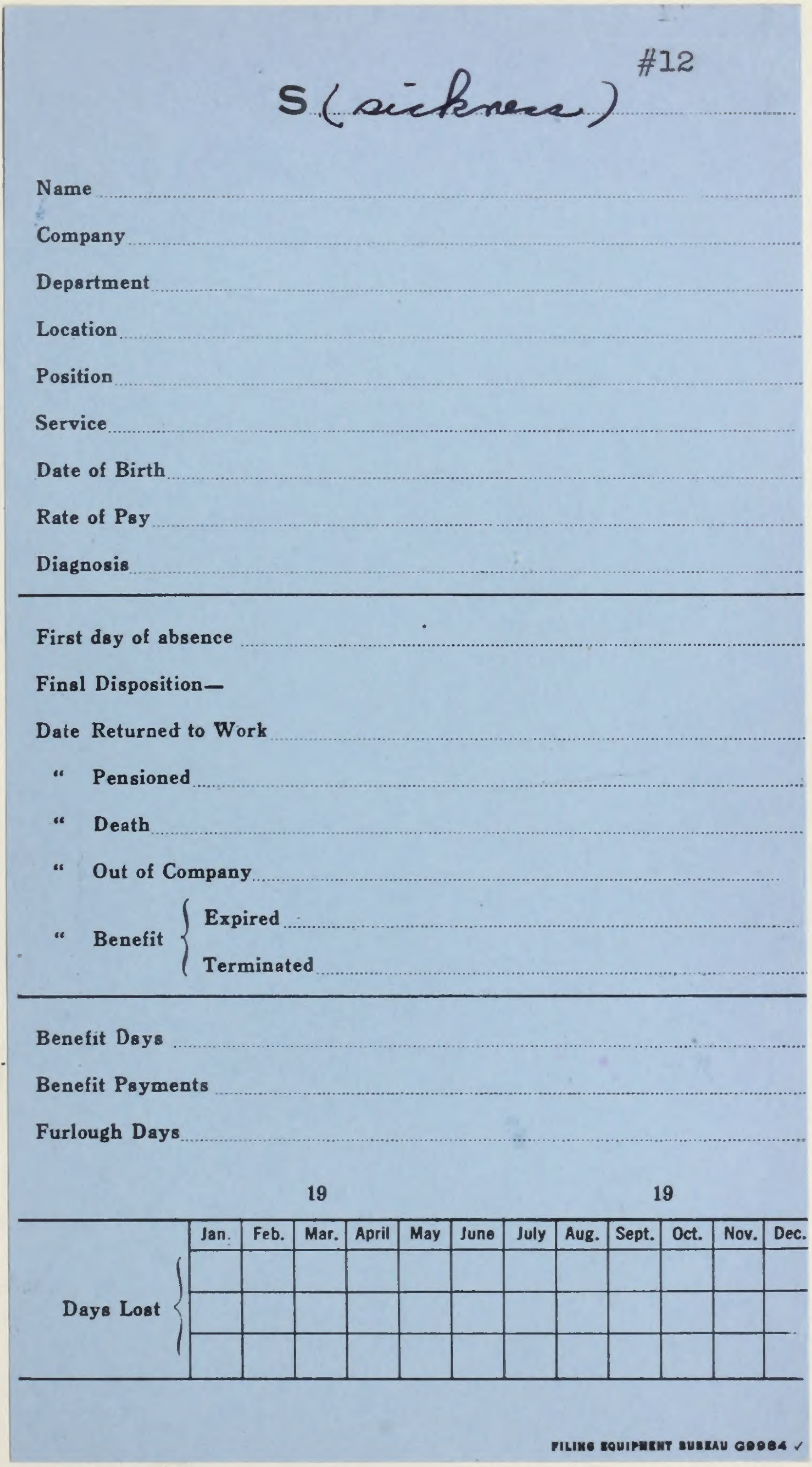
By .... (Accounting Dept. Supv.)

SIGNED .... (employee)

TITLE .... DATE ....

DEPT. .... DIV. ....

DIST. .... OFFICE ....



#12

S (sickness)

Name

Company

Department

Location

Position

Service

Date of Birth

Rate of Pay

Diagnosis

First day of absence

Final Disposition—

Date Returned to Work

" Pensioned

" Death

" Out of Company

" Benefit { Expired

Terminated

Benefit Days

Benefit Payments

Furlough Days

	19						19					
	Jan.	Feb.	Mar.	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
Days Lost												

FILING EQUIPMENT BUREAU G9984 ✓

FORM 158 BM

LAST NAME FIRST NAME MIDDLE NAME OR INITIAL

RESIDENCE: CITY OR TOWN STREET STATE

REPORT OF SICKNESS DISABILITY

1. LOCATION ______ DEPARTMENT DIVISION OFFICE
2. OCCUPATION: ______ (OCC. CODE) ______ P. R. NO. ______
3. MARITAL STATUS: (CHECK ONE) SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ HAS EMPLOYEE PREVIOUSLY RECEIVED "SICKNESS" BENEFITS: NO YES
4. FIRST FULL DAY OF ABSENCE ______
5. NAME OF ATTENDING PHYSICIAN: ______

   ADDRESS ______
6. NATURE OF DISABILITY: ______
7. WAR SERVICE—YES: NO

   GOV'T COMPENSATION—YES: NO

   IF RECEIVING GOVERNMENT COMPENSATION:

   AMOUNT PER MONTH $

   EFFECTIVE DATE

   NATURE OF DISABILITY

DATE ______ ______ SIGNATURE AND TITLE OF DESIGNATED SUPERVISOR MAKING REPORT.

SERVICE ON DATE (ITEM 4) ______ YEARS ______ MONTHS

RATE OF PAY ______ DATE OF BIRTH ______

HAS EMPLOYEE BEEN PAID "SICKNESS" BENEFITS UNDER PLAN DURING 13 WEEKS IMMEDIATELY PRECEDING DATE (ITEM 4) YES: NO

DATE ______ DIV. ASST. AUDITOR OF DISBURSEMENTS ______

MEDICAL APPROVAL IS GIVEN:

TO ______ INCL. PER ______

TO ______ INCL. PER ______

TO ______ INCL. PER ______

TO ______ INCL. PER ______

FULL EXPIRES ______ 19 ___

HALF EXPIRES ______ 19 ___

BEN

#13

LAST NAME FIRST NAME MIDDLE NAME OR INITIAL

RESIDENCE: CITY OR TOWN STREET STATE

REPORT OF SICKNESS DISABILITY

1. LOCATION ______ DEPARTMENT DIVISION OFFICE
2. OCCUPATION: ______ (OCC. CODE) ______ P. R. NO. ______
3. MARITAL STATUS: (CHECK ONE) SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ HAS EMPLOYEE PREVIOUSLY RECEIVED "SICKNESS" BENEFITS: NO YES
4. FIRST FULL DAY OF ABSENCE ______
5. NAME OF ATTENDING PHYSICIAN: ______

   ADDRESS ______
6. NATURE OF DISABILITY: ______
7. WAR SERVICE—YES: NO

   GOV'T COMPENSATION—YES: NO

   IF RECEIVING GOVERNMENT COMPENSATION:

   AMOUNT PER MONTH $

   EFFECTIVE DATE

   NATURE OF DISABILITY

DATE ______ ______ SIGNATURE AND TITLE OF DESIGNATED SUPERVISOR MAKING REPORT.

SERVICE ON DATE (ITEM 4) ______ YEARS ______ MONTHS

RATE OF PAY ______ DATE OF BIRTH ______

HAS EMPLOYEE BEEN PAID "SICKNESS" BENEFITS UNDER PLAN DURING 13 WEEKS IMMEDIATELY PRECEDING DATE (ITEM 4) YES: NO

DATE ______ DIV. ASST. AUDITOR OF DISBURSEMENTS ______

MEDICAL APPROVAL IS GIVEN:

TO ______ INCL. PER ______

TO ______ INCL. PER ______

TO ______ INCL. PER ______

TO ______ INCL. PER ______

FULL EXPIRES ______ 19 ___

HALF EXPIRES ______ 19 ___

MED

#14

NEW ENGLAND TELEPHONE & TELEGRAPH CO.—MEDICAL DEPARTMENT
245 STATE STREET, BOSTON, MASSACHUSETTS

APPOINTMENT REQUEST

APPOINTMENT SUPERVISOR:

Will you please make an appointment to have ____________________
of ____________________ Department report at this office for examination on
____________________ Time ____________ to be seen by Doctor ____________________
and Dr. ____________________.

Please return this request to me today and report below status of appointment.

Date ____________________ Physician ____________________

REPORT

DR. ____________________

Employee's supervisor ____________________ notified. Employee will report as above. ☐ Check if o.k.

Employee unable to report—reason: ____________________
____

Date ____________________ Appointment Supv. ____________________

Form 158N

No. #18

Employees' Benefit Committee.

Date ____________

May I have your permission to leave home during my present disability from ____________ to ____________

My address would be

If this permission is granted, I agree to keep my superior informed weekly, regarding my condition.

The above request is made in accordance with Section 8, Paragraph 10 of the Plan for Employees' Pensions, Disability Benefits and Death Benefits which is as follows:-

"Disabled employees wishing to leave home shall obtain from the Committee written approval of absence for a specified time and furnish it satisfactory proof of disability while absent, otherwise no benefits shall be paid for such period of absence."

NOTED:

____________ ____________

(Signature of Employee)

……………………………………………………………

Permission is hereby granted to

____

as per Form 158N, Number ____________, to leave home for the period from ____________ to ____________. This permission is granted in accordance with Section 8, Paragraph 10 of the Plan for Employees' Pensions, Disability Benefits and Death Benefits and disabled employee has agreed to keep superior informed weekly regarding his condition.

Secretary, Employees' Benefit Committee.

Date ____________

Form 158G
Oct. 9, 1926

REPORT OF RETURN TO WORK

#19

Date: 19 .

1. Name of Employee:

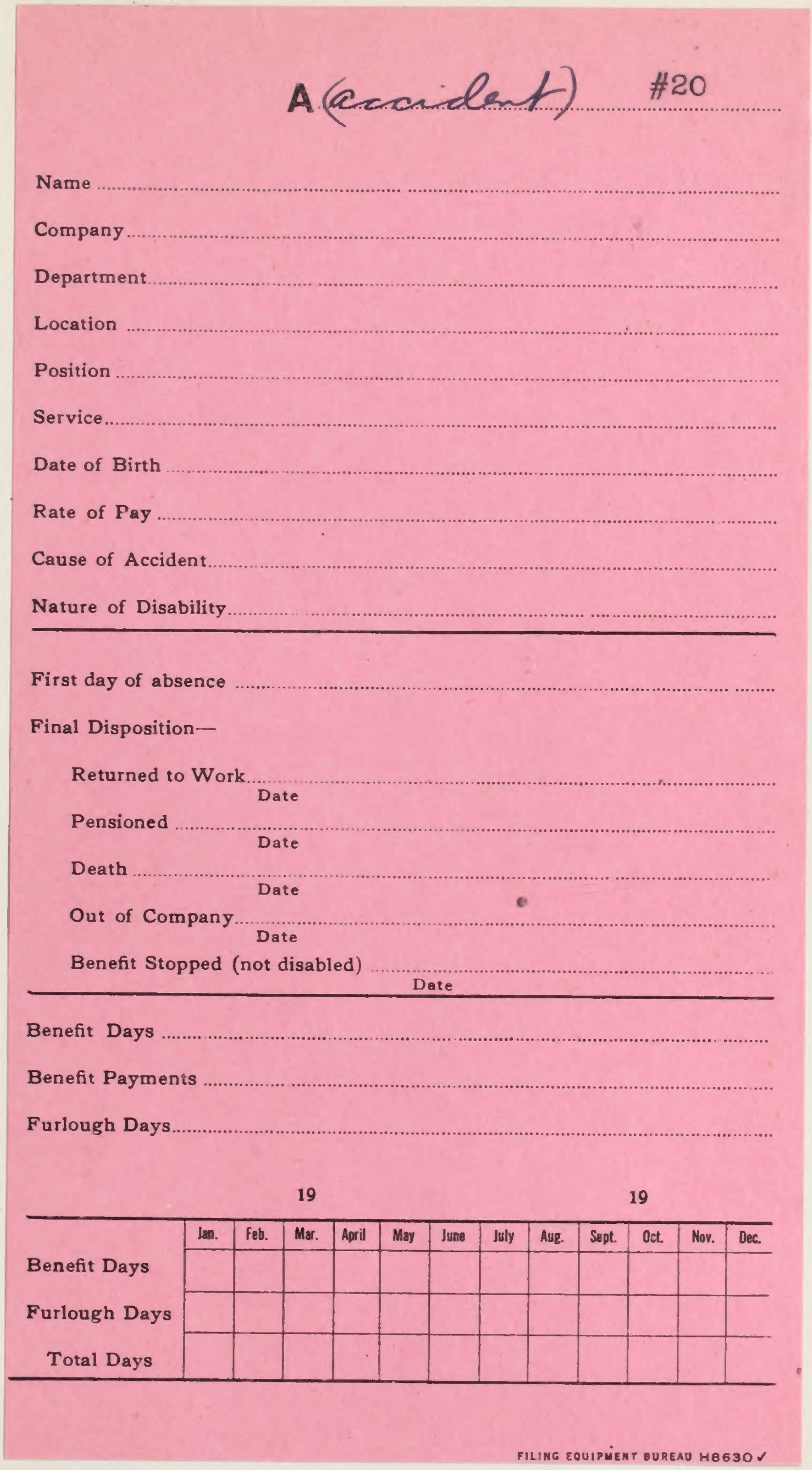
2. Where Employed: (City or Town); (Department)

3. Date of report of disability: 19 .

4. Reason for absence; sickness / accident } (Cross out one)

5. Date returned to duty: 19 .

(Signature and title of employee reporting)



A (accident) #20

Name

Company

Department

Location

Position

Service

Date of Birth

Rate of Pay

Cause of Accident

Nature of Disability

First day of absence

Final Disposition—

Returned to Work
Date

Pensioned
Date

Death
Date

Out of Company
Date

Benefit Stopped (not disabled)
Date

Benefit Days

Benefit Payments

Furlough Days

19 19

	Jan.	Feb.	Mar.	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
Benefit Days												
Furlough Days												
Total Days												

FILING EQUIPMENT BUREAU H8630 ✓

#21

Form 158E
7-1-40

NEW ENGLAND TELEPHONE AND TELEGRAPH COMPANY

INITIAL REPORT OF ACCIDENT TO EMPLOYEE

(In course of employment)

DEPARTMENT.. **DISTRICT**..

Name..

Sex.................... **Married or Single**..

Home Address..

Occupation:.. **Age:**.. **Years**

Date of Accident:.. **Time:**.. **a.m. p.m.**

Date Reported by Employee:.............................. **Time:**.. **a.m. p.m.**

Reported to:..

Place of Accident..
(Street No.) (City or town) (State)

Describe the Injury:..

....

....

State How Accident Occurred:..

....

....

Was First Aid Rendered?.............................. **By Whom?**..................................

Was Physician Consulted?...
(Give name and address)

Did Employee Return to Work on Day of Accident?..

Did Employee Return to Work the Following Day?...

Witnesses:...

....

Wkly. Rate of Pay:.............................. **Service**.................... **Years**.................... **Mos.**

Date.................................... ....
(Signature of Supervisor)

NOTE

Form must be typed or in ink.

If the injured employee had medical treatment, Form 158L must be forwarded promptly.

If the injured employee loses time as a result of this accident, Forms K-15 and 158-A must be forwarded on the first day of absence.

The object of this report is to supply information to be used in preventing similar accidents in the future.

Prepare separate accident report for each employee injured.

Preliminary Report
Condition of Injure

31. Did employee resume his regular daily work?..............................If not, what is estimated time off regular daily work ?....................

.... 32. To what work, if any, other than regular daily work was employee temporarily assigned?

....When?..............................

33. First full day of absence from all Co. duties..

Fill in spaces below with code numbers applying to this particular accident.

Nature of Work at Time of Accident	Underlying Cause of Accident	Cause of Accidental Injury	Location and Nature of Injury

Person furnishing information .... Position .... Address ....

Person making out form .... Position .... Address .... Date ....

Noted by:

Name .... Title .... Date ....

Name .... Title .... Date ....

Name .... Title .... Date ....

Verified with employee's service record and found correct..
Auditor

Doctor #23

Address

Introducing M

an employee of this Company who is referred for examination of

Appointment made for Company charge Yes No

Please send written report to

D. L. Lynch, M. D.

NEW ENGLAND TELEPHONE & TELEGRAPH COMPANY
245 STATE STREET BOSTON, MASS.

FORM 43
6-9-25

New England Telephone and Telegraph Co. #24

REPORT FROM..........................MEDICAL OFFICE

To M...

Title ....

Address...

Employee's Name...

Employed at.. as..

Reported at this office today { at suggestion of .... / volitionally ....

MEDICAL OPINION

Unable to work		Is improved	
Able to do regular work		Is unimproved	
Able to do some work		Permitted to leave home	
Should remain at work		Referred to Private Physician	
Should return to work on		Referred for Special Exam.	

Employee has a reappointment at this office on ....

EXPLANATORY NOTE

....

....

....

....

....

....

....

Date .... D L Lynch M D .....M. D.
Medical Director

Bibliography

BIBLIOGRAPHY

Books

Davis, Eleanor, "Company Sickness Benefit Plans for Wage Earners", Princeton University Press, Princeton, New Jersey, 1936

Davis, Michael M., "America Organizes Medicine", Harper and Brothers, New York, 1941

De Kruif, Paul, "Kaiser Wakes the Doctors", Harcourt, Brace and Company, New York, 1941

Encyclopedia of Social Science, MacMillan Company, New York, 1932; Cohen, Joseph, "Health Insurance," Volume II Jones, L. W. and Jones, Barbara, "The Economic Organization of Medicine", Volume X

Falk, I. S., "Security Against Sickness--A Study of Health Insurance", Doubleday, Doran, New York, 1936

Falk, I. S.; Rorem, C. Rufus; Ring, Martha D.; "The Costs of Medical Care", University of Chicago Press, Chicago, Illinois

Gibbon, I. G., "Medical Benefit in Germany and Denmark", E. P. Dutton, and Company, New York, 1913

Goldman, Franz, "Prepayment Plans for Medical Care", Joint Committee of the Twentieth Century Fund and Good Will Fund, Medical Administration Service Inc., New York, 1941

"Handbook of Sickness Insurance, State Medicine, and the Cost of Medical Care", American Medical Association Press, Chicago, Illinois, 1939

Hartman, Gerhardt, "Hospital Mal Practice Insurance", University of Chicago, Press, Chicago, Illinois, 1943

Hirschfield, Gerhard, "Social Security, Past, Present, and Future", American Taxpayers Association, Washington, D. C. 1944

Lape, Esther, "American Medicine", American Foundation, New York, 1937

Millis, Harry Alvin, "Sickness and Insurance", The University of Chicago Press, Chicago, Illinois, 1941

Books (Continued)

Orr, Douglas W., and Jean Walker, "Health Insurance with Medical Care--The British Experience", The MacMillan Company, New York, 1938

Reed, Louis S., "Health Insurance--The Next Step in Social Security", Harper and Brothers, New York, 1932

Rorum, C. Rufus, and Musser, John H., "Group Payment for Medical Care in the Stanocola Employees Medical and Hospital Association", Julius Rosenwald Fund, New York, 1932

"The Nation's Health", U. S. Interdepartmental Committee to Coordinate Health and Welfare Activities, U. S. Government Printing Office, Washington, D. C., 1935

Williams, Pierce, "The Purchase of Medical Care Through Fixed Periodic Payments", National Bureau of Economic Research, New York, 1932

Pamphlets and Magazine Articles

Abell, Irvin, "Medicine in the Changing Social Order", Kentucky Medical Journal, Volume 30, Number 4, April, 1938

Adams, James M., "Stanocola Medical Care Plan", Journal of the American Medical Association, Volume 126, Number 6, October 7, 1944

American Medical Association Bulletin, "Critical Analysis of Sickness Insurance", Volume 29, Number 44, April, 1944

American Medical Association Bulletin, "Medical Service Plans--A Report by the Bureau of Medical Economics", Volume 29, Number 44, April, 1944

Avnet, Helen Hershfield, "Costs of Physicians' Services Under a Prepayment Plan", Medical Care, Volume 1, Number 1, January, 1941

Bishop, Eugene L., "Medical Care at a T. V. A. Project", Medical Care, Volume 2, Number 3, July, 1942

Bloom, M. C., "Variations in Current Industrial Medical Service Plans", Journal of the American Medical Association, Volume 126, Number 6, October 7, 1944

Bray, C. B., "An Industrial Medical Care Plan", Medical Care, Volume 1, Number 1, January, 1941

Brown, Morton W., "An Experimentation in Meeting Medical Needs by Voluntary Action", Law and Contemporary Problems, Volume 6, Number 4, Autumn, 1939

Brenner, Paul V., "Medical Insurance Plans for Federal Assistance Cases in Kansas", Medical Care, Volume 3, Number 2, May, 1943

Business Week, "Blue Cross Gains", March 18, 1944

Business Week, "Ford, Fast One", February 14, 1942

Business Week, "For Workers, Veterans, and Candidates", June 12, 1943

Business Week, "Insurance Idea", January 8, 1944

Business Week, "Management Shift", March 31, 1945

Business Week, "No Pay Increase", July 10, 1943

Pamphlets and Magazine Articles (Continued)

Business Week, "State Medicine, An Answer", December 16, 1939

Business Week, "Union Group Insurance", February 28, 1944, March 2, 1944

Butler, Alan M., "Medical Freedom and the Wagner Bill", Medical Care, Volume 4, Number 1, February, 1944

Clark, Katheryn C., "Insurance Companies and the Wagner Bill", Medical Care, Volume 3, Number 4, November, 1943

Close, Katheryn, "Money While You're Sick", Survey, Volume 79, Number 12, December, 1943

Committee on Research in Medical Economics, "Principles of a Nationwide Health Program", New York, 1944

Congressional Record--Senate, June 3, 1943

Crew, M. C., Daniels, Elmer, "A Chicago Teachers' Union Medical Center Plan", Medical Care, Volume 1, Number 1, January, 1941

Davis, Graham, "Content and Administration of a Medical Care Program", American Journal of Public Health, Volume 4, Number 12, December, 1944

Davis, Michael M., "Health for the Nation", Survey Graphic, Volume 33, Number 12, December, 1944

Davis, Michael M., "Health Insurance Plans Under Medical Societies", Medical Care, Volume 3, Number 3, August, 1943

Davis, Michael M., "New Health Plan", New Republic, Volume 33, Number 12, December, 1944

Davis, Michael M., "Statesmen Discover Medical Care", Survey Graphic, Volume 34, Number 3, March, 1945

Davis, Michael M., "The A. M. A. Case", Survey Graphic, Volume 31, Number 12, December, 1942

Davison, Ronald, "Britain's Health Service", New Republic, Volume 110, Number 20, May 15, 1944

Pamphlets and Magazine Articles (Continued)

Decourt, Fernald, "The Abuses in Sickness Insurance--Will Majority of Them Disappear", Review International, May, 1944

De Kruif, Paul, "Health at Fifty Cents Weekly", Science News Letter, Volume 44, Number 11, September 11, 1943

De Kruif, Paul, "Master Builder", Time, Volume 42, Number 11, September 20, 1943

Falk, I. S., Reed, L. S., and Saunders, B. S., "Some Problems in the Formulation of a Disability Insurance Program", Law and Comtemporary Problems, volume 6, Number 4, Autumn, 1939

Falk, I. S., "The Content and Administration of a Medical Care Program", American Journal of Public Health, Volume 34, Number 12, December, 1944

Federal Security Agency, Social Security Board, Bureau of Research and Statistics, "Prepayment Medical Care Organizations", Memorandum Number 55

Fishbein, M., "Medical Insurance Plans,,Which System Will Guarantee the Best Medical Care", Vital Speeches, Volume 11, Number 1, January, 1945

Fisher, Austin M., "Insure Your Workers' Health", Volume 44, Number 262, February, 1944

Fortune, "U. S. Medicine in Transition--Growing Trend Toward a Compulsory Federal Insurance Law", Volume 30, Number 16, December, 1944

Furnas, J. C., "The Cross in Blue", Saturday Evening Post, Volume 216, Number 15, October 2, 1943

Garfield, Sidney R., "Family Health Plan", Circular

Garfield, Sidney R., "Health Plan Principles in the Kaiser Industry", Journal of the American Medical Association, Volume 26, Number 6, October 7, 1944

Goldman, Franz, "Medical Care in Industry", Medical Care, Volume 1, Number 3, September, 1941

Goldman, Franz, "Prepayment for Medical Care", Medical Economics, October, 1941

Pamphlets and Magazine Articles (Continued)

Goldman, Franz, "Voluntary Health Insurance", Survey Midmonthly, Volume 77, Number 3, March, 1941

Hege, Dr. J. Roy, "Content and Administration of a Medical Program", American Journal of Public Health, Volume 34, Number 12, December, 1944

Hollingsworth, Helen,"Family Expenditures for Medical Care, Five Regions", U. S. Department of Agriculture, Bureau of Home Economics, Miscellaneous Publication, Number 42, 1941

Johnson, Julia, "Socialization of Medicine", Supplement to Reference Shelf, Volume 10, Number 5, December, 1935

Jones, Edward M., "Endicott-Johnson Medical Plan", Journal of the American Medical Association, Volume 126, Number 3, October 7, 1944

Journal of the American Medical Association, "The American Medical Association on Trial", Volume 116, Number 2, February 15, 1941

Ketchum, J. C., "Why Medical and Hospital Service Plans Should be Jointly Operated", Journal of the American Medical Association, Volume 117, Number 8, August, 1943

Klein, C. R., "Cost of a Beveridge Plan in the United States", Quarterly Journal of Economics, Volume 58, Number 3, May, 1944

Klem, Margaret, "Prepayment Medical Care Organizations", Federal Security Agency, Social Security Board, Bureau of Research and Statistics, Memorandum Number 55, June, 1944

Klem, Margaret, "Some Recent Developments in Voluntary Health Insurance", Social Security Bulletin, Volume 5, Number 8, August, 1942

Laird, Angus, "Cooperative Plans in Tampa, Florida", Medical Care, Volume 3, Number 3, July, 1943

Linford, Alton A., "Dispute Over the United States Health Insurance Act", Public Affairs, Volume 7, Number 3, June, 1944

Pamphlets and Magazine Articles (Continued)

Linford, Alton A.; Houser, Gerald F.; Phippen, Walter G.; and Cabot, Hugh, "Should Social Security be Extended Further into the Fields of Medical Care and Hospital Service", Massachusetts Central Health Council, 1944

Mannix, John R.,"Voluntary Non-Profit Prepayment Plan for Health Care", Journal of the American Medical Association, Volume 124, Number 9, February 26, 1944

McCann, James C., "Medical Society Prepayment Program--Lessons Learned from the Experiences in Massachusetts", Journal of the American Medical Association, Volume 126, Number 6, October 7, 1944

McCann, James C., "Organization of a Medical Society Prepayment Plan", Medical Care, Volume 2, Number 2, April, 1942

Medical Care, "Actions and Opinions Among Medical Societies", Volume 2, Number 4, November, 1943

"Fortune's Poll on Medical Care", Volume 3, Number 3, June, 1942

"Health Insurance", Volume 2, Number 1, January, 1942

"Labor Union Plans", Volume 2, Number 2, April 1, 1942

"Medical Care in Industry", Volume 2, Number 1, January, 1942

"Medical Society Opinion on the Wagner Bill", Volume 3, Number 4, November, 1943

"New Zealand Medicine", Volume 2, Number 1, January, 1942

"Review of the Year--Origins of the Wagner Bill", Volume 4, Number 1, February, 1944

"United Automobile Union Workers Establish a Health Program", Volume 2, Number 3, November, 1942

Medical Economics, "Prepayment for Medical Care", October, 1941

Pamphlets and Magazine Articles (Continued)

Monthly Labor Review, "Group Insurance Plan of the United States Steel Corporation", Volume 14, Number 8, August, 1935

Moses, Herbert W., "Benefit Plan Changed", Edison News, Volume 1, Number 1, July, 1940

Moulton, Joseph W., "Content and Administration of a Medical Care Program", American Journal of Public Health, Volume 4, Number 12, December, 1944

Murray, J. E., "Medical Care for All Americans", New Republic, Volume 111, Number 2, July 10, 1944

New Republic, "Dirty Work by the Doctors", Volume 109, Number 3, August 30, 1943

Newsweek, "Federalized Medicine", Volume 22, Number 23, December 6, 1943

Orear, Leslie, "Chicago Packing House Workers and Their Problem of Medical Care", Medical Care, Volume 1, Number 1, January, 1941

Otey, Elizabeth L., "Cash Benefits Under Voluntary Disability Insurance", Social Security Bulletin, Volume 2, Number 2, February, 1939

Perrot, George St. J., "Content and Administration of a Medical Care Program", American Journal of Public Health, Volume 34, Number 12, December, 1944

Petras, Lewis Petro, "Search for Health and Security--Chicago Post Office Clerks Union", Medical Care, Volume 1, Number 1, January, 1941

Price, Leo, "Health Program of the International Ladies' Garment Workers' Union," Monthly Labor Review, U. S. Department of Labor, October, 1939

Price, Leo, "Periodic Health Examinations", Industrial Medicine, August, 1942

Reed, Louis, "Costs and Benefits Under Prepayment Medical Service Plans", Social Security Bulletin, Volume 3, Number 3, March, 1940

Reed, Louis, "Legislative Proposals for Compulsory Health Insurance", Law and Contemporary Politics, Volume 6, Number 4, Autumn, 1939

Pamphlets and Magazine Articles (Continued)

Ross, Mary, "The Case of the Ross-Loos Clinic", Survey Graphic, June, 1935

Saturday Evening Post, "Do We Need Federal Medicine", Volume 216, Number 14, September 25, 1943

Saunders, Barker and Klem, Margaret C., "Services and Costs in a Prepayment Medical Care Plan", Medical Care, Volume 2, Number 3, June, 1944

Sinai, Dr. Nathan, "Content and Administration of a Medical Care Program", American Journal of Public Health, Volume 34, Number 12, December, 1944

Sinai, Dr. Nathan, "Present Status of Health Insurance in United States", American Journal of Public Health, Volume 34, Number 2, February, 1944

Stocking, Ruth K., "Certification of Disability in Social Insurance", Social Security Bulletin, Volume 4, Number 6, June, 1941

Survey, "New York City's Health Plan", Volume 80, Number 10, October, 1944

Survey, "Contrast--Controversies on Methods of Extending Medical Care", Volume 81, Number 1, January, 1945

Time, "Blue Cross", Volume 43, Number 4, January 24, 1944

United States Bureau of Labor Statistics, "Beneficial Activities of American Trade Unions", Bulletin Number 465, Washington Government Printing Office, 1928

Walker, Lester, "Shield vs. Health Hazards", Nation's Business, Volume 33, Number 2, February, 1945

Weigert, Helga, "Labor's Health Programs in Three Cities", Medical Care, Volume 3, Number 2, May, 1943

Williams, Pierce, "Alternatives to Compulsory Health Insurance", Annals of the American Academy of Social and Political Science, Volume 170, November, 1933

Wittmer, John J., "Variations in Current Industrial Medical Service Plans", Journal of the American Medical Association, Volume 126, Number 6, October 7, 1944

Miscellaneous Publications

American Bosch Mutual Benefit Association, "By Laws", April 1, 1943

Batchelder and Snyder Company Inc., "Employees Group Insurance Plan", Boston, Massachusetts, 1943

Boston Edison Company, "A New Hospital and Surgical Benefit Plan", December 1, 1944

Boston Edison Company, "Edison Employees' Handbook", January 1, 1930

Colonial Beacon Oil Company, "Colonial Beacon Employees' Hospital and Medical Association Inc.", Everett, Massachusetts, 1941

Commonwealth of Massachusetts, State Advisory Council, Division of Employment Security, "Report on Sickness Benefits", Wright and Potter Printing Company, Boston, Massachusetts, November 1, 1944

Filene's, William Son's Company, "By Laws of the Filene's Employees Benefit Society", Boston, Massachusetts, November, 1943

Garfield, Sidney R., "First Annual Report of the Permanente Foundation Hospital," Permanente Foundation Medical Bulletin, Volume 1, Number 1, January, 1944

Kaiser, Henry J., "A Health Plan for Employees of the Richmond Shipyards", Richmond, California, 1942

Kaiser, Henry J., "Permanente Health Foundation Hospital Family Health Plan", Richmond, California, 1942

Kaiser, Henry J., "Your Health Plan--Northern Permanente Foundation", Vancouver, Washington, 1942

La Guardia, F. H., "Sunday Broadcast to the People of New York City", April 30, 1944

Massachusetts Hospital Service Inc., "Blue Cross--The Non-Profit Plan", 1944

Massachusetts Medical Society, "The Blue Shield", 1944

Massachusetts Medical Service Inc., "The Doctors Answer to Socialized Medicine", 1944

Miscellaneous Publications (Continued)

Metropolitan Life Insurance Company, "Health Insurance--A Summary of Some Existing Governmental Plans Providing Protection in the Event of Sickness or Invalidity", Monograph Number 3, June, 1931

Metropolitan Life Insurance Company, "Social Insurance Legislation", Monograph Number 4, January, 1932

National Physicians Committee for the Extension of Medical Service,"Opportunity for Private Enterprise", or "Benefits for Business Through Cooperative Group Insurance", Chicago, Illinois, 1944

New England Telephone and Telegraph Company, "Plan for Employees Pensions, Disability Benefits, and Death Benefits", January, 1940

Newman, Pauline, "Questions and Answers", The Union Health Center of the International Ladies' Garment Workers' Union, Anco Press Inc., New York, December, 1940

Prudential Life Insurance Company of America, "Highlights of Prudential Group Insurance", Prudential Press, Newark, New Jersey, 1943

Prudential Life Insurance Company of America, "What Every Employer Should Know About Group Insurance", Prudential Press, Newark, New Jersey, 1943

Seventy-Eighth Congress, "H. R. 2861" and"S1161", June 3, 1943

Tennessee Coal Iron and Railroad Company, "A Description of Its Works and Activities", Birmingham, Alabama, 1938

Speeches

Bagnell, Dr. Elmer, "Proposed Plans for Medical Care", Speech Before the Health Council of Boston, March 8, 1945

Butler, Dr. Alan, "Proposed Plans for Medical Care", Speech Before the Health Council of Boston, March 8, 1945

Butler, Dr. Alan, Speech at Harvard Medical School, March 9, 1945

Faxon, Dr. Nathanial W., "Health Insurance Plans", Speech at Harvard Medical School, February 2, 1945

Faxon, Dr. Nathanial W., "Proposed Plans for Medical Care", Speech Before the Health Council of Boston, March 8, 1945

Lee, Roger, "Health Insurance", Speech Before Suffolk Medical Society, November 18, 1944

Saltonstall, Leverett, "Health Insurance", Speech Before Suffolk Medical Society, November 18, 1944

Willinsky, Dr. Charles P., "Proposed Plans for Medical Care", Speech Before the Health Council of Boston, March 8, 1945

Interviews

Beacher, Frank, Assistant Manager Boston Office, General Electric Company

Gargill, Samuel, Medical Director, William Filene's Son's Company

Linford, Alton A., Professor of Social Insurance, Simmons College, School of Social Work

Lynch, Daniel, Medical Director, New England Telephone and Telegraph Company

Miller, Bessie, Insurance Agent

Monroe, Noel, Medical Director, Boston Edison Company

*
368.42
So4m
c.1

*368.42

Solomon So4m
c.1

Medical insurance in industry

DATE	ISSUED TO
10.45	Doris Alberghini
[illegible]	[illegible]

BOSTON UNIVERSITY
1 1719 02570 6989